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No. 08- ____

IN THE

Supreme Court of the United States

GOLDEN GATE RESTAURANT ASSOCIATION,
Petitioner,

v.

CITY AND COUNTY OF SAN FRANCISCO,
Respondent,

SAN FRANCISCO CENTRAL LABOR COUNCIL, *et al.*,
Intervenors / Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

San Francisco's Health Care Security Ordinance—a "pay-or-play" law—mandates either ongoing employer contributions at set minimum rates for employee health-benefits or equal payments to the City's Health Access Program, along with extensive recordkeeping and reporting and disclosure requirements. In a decision directly conflicting with Supreme Court ERISA preemption decisions, the Ninth Circuit rejected petitioner's ERISA-preemption challenge despite repeated *amicus* support by the Secretary of Labor. Identifying "an issue of exceptional national importance," an eight Judge dissenting opinion from denial of rehearing *en banc*, including Chief Judge Alex Kozinski, observed that the decision "creates a circuit split with the Fourth Circuit . . . , renders meaningless the [ERISA preemption] tests the Supreme Court set out in *Shaw v. Delta Airlines* . . . , and disregards the "need for nationally uniform plan administration." It also warned that the decision "will undoubtedly serve as a roadmap in jurisdictions across the country on how to design and enact a labyrinth of laws requiring employer compliance on health care expenditures, thereby creating the very kind of health care balkanization ERISA was intended to avoid."

The Question Presented is:

Whether ERISA section 514(a), 29 U.S.C. § 1144(a), preempts local laws mandating ongoing employer contributions for employee health-benefits, or alternative payments to a local government, and extensive recordkeeping and reporting and disclosure requirements, a question on which the courts of appeals are in conflict.

RULE 14.1(b) LISTING AND RULE 29.6 NOTATION

Petitioner is the Golden Gate Restaurant Association. Respondent is the City and County of San Francisco. Intervenors/Respondents are the San Francisco Central Labor Council, Service Employees International Union, Local 1021, SEIU United HealthCare Workers-West and UNITE HERE! Local 2.

Petitioner is a private non-profit corporation. It has no parent company and there is no publicly owned company that owns any stock of the petitioner.

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CITY AND COUNTY OF SAN FRANCISCO,
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Intervenors / Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

PETITION FOR WRIT OF CERTIORARI

Petitioner, Golden Gate Restaurant Association ("Golden Gate"), respectfully submits that a writ of certiorari should issue to review the judgment and opinion of the United States Court of Appeals for the Ninth Circuit in this case, an opinion which conflicts with *Retail Industry Leaders Ass'n v. Fielder*, 473 F.3d 180 (4th Cir. 2007).

OPINIONS BELOW

The opinion of the Court of Appeals is reported at 546 F.3d 639 (9th Cir. 2008), and is reprinted in the Appendix ("App.") at 1a to 40a. The concurring and

dissenting opinions to the denial of rehearing *en banc* (App. 41a to 61a) are reported at 558 F.3d 1000 (9th Cir. 2009). The Secretary of Labor's *amicus* brief in support of rehearing appears at App. 62a to 82a. The District Court's opinion granting summary judgment to Golden Gate (App. at 83a to 103a) is reported at 535 F.Supp.2d 968 (N.D. Cal. 2007). The relevant provisions of San Francisco's Health Care Security Ordinance and regulations appear at App. 106a to 158(a).

JURISDICTION

The Court of Appeals' order denying rehearing *en banc* was entered on March 9, 2009. This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

The relevant provisions of the federal statute involved in this case are reproduced at App. 104a to 106a.

STATEMENT OF THE CASE

This case raises a critically important, recurring question relating to the preemptive scope of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq*. The controversy, which has already divided the circuits, centers on recent attempts by state and local governments to mandate employer contributions for employee health-benefits through the device of "pay-or-play" laws, sometimes known as "fair-share" laws.

Employee benefit plans are "affected with a national public interest"[1] as reflected in the current healthcare-reform efforts at the national level.

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[1] ERISA section 514(a), 29 U.S.C. § 1144(a).

ERISA governs employee benefit plans and establishes a scheme which encourages, but does not mandate, that employers provide benefits for their employees.[2] Although ERISA sets "various uniform standards, including rules concerning reporting, disclosure, and fiduciary responsibility" for plans, "private parties, not the Government, control the level of benefits."[3] Congress designed this flexibility to encourage employers to adopt uniform employee benefit plans with streamlined administration and initially generous benefits, knowing they may amend or terminate the plans at any time.[4]

ERISA's preemption provision is at the very heart of the statute. This provision protects ERISA's central goals including the autonomy of plan sponsors to decide whether to provide plans at all and, if so, to establish plans with cost-effective, nationally-uniform benefits, benefit levels and administration.[5] Ensuring these objectives, ERISA preempts state and local laws that "prohibit" what is "permitted" by federal law,[6] "mandate[] employee benefit structures,"[7] impose "different regulations on plans and *plan sponsors* from jurisdiction to jurisdiction,"[8] or permit par-

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[2] *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983).

[3] *Curtiss-Wright Corp. v. Schoonenjongen*, 514 U.S. 73, 78 (1995).

[4] *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 511 (1981).

[5] *Shaw*, 463 U.S. at 105 n. 25; *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658 (1995).

[6] *Travelers*, 514 U.S. at 658.

[7] *Id.*

[8] *Egelhoff v. Egelhoff*, 532 U.S. 141, 146-147 (2001)(emphasis added).

ticipants to obtain "benefits in excess of what plan administrators intended to provide, and in excess of what the plan provides to employees in other states."[9]

A. Development of "Pay-Or-Play" Laws and the Challenge to These Laws

Although "pay-or-play" laws are recent developments, their DNA traces back to the employer mandated-contributions and noncompliance-penalty provisions of the Hawaii Prepaid Health Care Act held ERISA-preempted over a quarter century ago. *Standard Oil Co. of Calif. v. Agsalud*, 633 F.2d 760 (9th Cir. 1980), *summarily aff'd*, 454 U.S. 801 (1981).[10]

Congress wanted to leave employee welfare benefit plans completely voluntary.[11] As a result, plan sponsors have the right under ERISA "for any reason at any time, to adopt, modify, or terminate welfare plans."[12] Congress knew that if it placed a heavy regulatory-hand on welfare plans, as it did with pension plans in terms of regulating minimum participation, funding, vesting and plan termination, employers would be likely to abandon health-plans entirely, the exact opposite of Congress's goal.

One of Congress's purposes in enacting ERISA's broad preemption provision was to foreclose the employer contribution mandates in the health-reform

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[9] *Id.*

[10] Shortly thereafter, Congress amended ERISA to provide a narrow exemption for the Hawaii Act, making clear that the amendment did not establish a precedent for amendments for any other state laws Pub.L.No. 97-473, § 301(b), 96 Stat. 2605, 2612 (1983).

[11] *Curtiss-Wright.*, 514 U.S. at 78.

[12] *Id.*

statutes that were precursors to the "pay-or-play" laws. These statutes included the Hawaii Act and a similar measure that was being considered in California.[13] The sheer number of the nation's political subdivisions—50 states and over 30,000 cities, counties and towns—ruled out the feasibility of local experiments with mandates applicable to sponsors of multistate plans. The spread of local mandates would collapse the nation's employee benefit plan system.

Congress also recognized that a state-by-state approach to employee benefits—rather than the carefully-balanced national approach adopted by ERISA—would unravel the great legislative compromise leading to ERISA's enactment.[14] Business and labor groups agreed to the continued voluntary nature of the employee benefit plan system, one to be governed by robust federal regulatory standards nationwide. This was only in exchange, however, for a broader-than-originally-proposed, "deliberately expansive"[15] preemption provision. ERISA sweeps aside not just state laws regulating areas specifically-covered by ERISA, but all state regulation in the employee benefit field outside of laws regulating insurance, banking or securities.[16]

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[13] *See* Michael S. Gordon, "Health Care Reform: Managed Competition and Beyond," Employee Benefits Research Institute, Issue Brief No. 135, 28-30 (March 1993).

[14] *See* Michael S. Gordon, "Introduction: The Social Policy Origins of ERISA," *Employee Benefits Law* (S.J. Sacher and J.I. Singer, eds., ABA, 2d ed., 2000), at c-cii.

[15] *Pilot Life Ins. Co. v. Dedeaux*, 491 U.S. 41, 46 (1987).

[16] ERISA sections 514(a), (b)(2)(A), 29 U.S.C. §§ 1104(a), (b)(2)(A).

The Ninth Circuit's decision demonstrates that Congress's concerns in 1974 are valid today. In addition to the "pay-or-play" law in San Francisco's Health Care Security Ordinance, Massachusetts has a "fair-share" law requiring certain employers to provide group health-insurance and pay premiums in set-amounts or face a penalty.[17] At the time this litigation was filed, at least 15 other states, including New York, New Jersey, Connecticut and Illinois, had comprehensive healthcare-reform bills or proposals under review.[18]

One of the many problematic aspects of the "pay-or-play" laws and proposals is that they impose not only differing employer minimum-contribution mandates based on different formulas, but also differing alternative government assessments and differing requirements for recordkeeping and reporting and disclosure. The laws also cause the siphoning of benefits from jurisdictions which do not have such laws to those which do. The laws apply both to local employers and employers located anywhere with a minimum threshold of local employees.

While well-intentioned, a "pay-or-play" approach focuses exclusively on local concerns and interests at the unacceptable cost of upending two of ERISA's most important principles. The first principle is that

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[17] MASS. REGS. CODE tit. 114, chap. 5, §§ 16.03(3)(c-d) (2009).

[18] *See* Peter Marathas, Jr., Robert W. Rachal and Yolanda Montgomery, "United States: Pay-or-Play State Health Insurance Laws and ERISA Preemption," *HR Advisor*, Vol. 14, No. 3, May/June 2008, 1-2. New Jersey's proposed "health-care-expenditures" bill is in A. 1966, 213th Leg., 2008-2009 Sess. Connecticut's proposed bill for employer contributions to a state-operated-healthcare-fund is in H.B. 6600, 2009 Gen. Assem. Reg. Sess., § 15(e).

employee benefit plans, including health-plans, are to be completely voluntary,[19] not subject to any mandates including employer contributions.[20] The second principle is that if a sponsor sets up a plan, the "'tailoring of plans and *employer conduct* to the peculiarities of the law of each jurisdiction' is exactly the burden that ERISA seeks to eliminate." *Egelhoff v. Egelhoff*, 532 U.S. 141, 151 (2001)(emphasis added). Moreover, there are many types of state-and-local fees and assessments that can fund healthcare-reform without doing what ERISA proscribes—"mandat[ing] employee benefit structures or their administration"[21] and "interfer[ing] with nationally uniform plan administration."[22]

Concerned about the extraordinary costs of compliance with diverse and conflicting "pay-or-play" laws and the resulting employee layoffs, business-relocations and closures, employer associations have challenged a number of these laws as ERISA-preempted.

In *Retail Indus. Leaders Ass'n v. Fielder*, 473 F.3d 180 (4th Cir. 2007), the Fourth Circuit sustained an employer association's ERISA preemption challenge to Maryland's "fair-share" law. The Secretary of Labor's *amicus* briefing supported this challenge, arguing that the law negated the "fundamental goal of ERISA preemption – the establishment of a uniform regulatory regime over employee benefit plans."[23]

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[19] *Curtiss-Wright, supra.*

[20] *Agsalud, supra.*

[21] *Travelers*, 514 U.S. at 658.

[22] *Egelhoff*, 532 U.S. at 148.

[23] Brief as *Amicus Curiae* at 10, available at http://www.dol.gov.sol/media/briefs/RILA(A)-11-07-2006.htm

The statute required large employers either to pay at least a specified percentage of total payroll for employees' health-insurance costs or to pay the shortfall as a penalty to the state for general-entitlement purposes. It also required employers to report annually the number of employees and the percentage-of-payroll spent on health-insurance.

Relying on *Fielder*, *supra*, a District Court in the Eastern District of New York held that ERISA preempts a Suffolk County "fair-share" law which required certain employers to provide at least $3.00 per hour in health-benefits to their employees, or to pay a civil penalty for the shortfall. *Retail Indus. Leaders Ass'n v. Suffolk County*, 497 F.Supp.2d 403 (E.D.N.Y. 2007).

The Ninth Circuit's decision in this case stands in direct conflict with *Fielder*, *supra*. The decision undoubtedly will lead to the development of more "pay-or-play" laws, as pointed out by the San Francisco City Attorney's description of the decision as "a road map for state and local governments" seeking to enact "fair share" laws.[24]

B. San Francisco's Health Care Security Ordinance

San Francisco's "pay-or-play" law is part of its Health Care Security Ordinance, S.F. Cal. Admin. Code, Ch. 14, which became effective in 2008.

The San Francisco Ordinance created the Health Access Program, known as "HAP." The HAP pools risks among program-participants and, through its

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[24] Jason Dearen, "Federal Court Upholds San Francisco Healthcare Program," *Los Angeles Times*, Sept. 30, 2008 (quoting City Attorney Dennis Herrera).

third-party administrator, maintains a network of approved San Francisco hospitals and clinics in much the same way as a private-HMO or PPO.

Local taxes, grants and other San Francisco revenues fund the overwhelming majority of the HAP's budget.[25] The HAP is open to uninsured City residents regardless of employment status. A resident may receive discounted medical services through the HAP by becoming a "participant" and paying quarterly income-based premiums, known as "participation fees."

If the Ordinance had stopped here, ERISA's preemption rules would not come into play. San Francisco went further, however, also requiring employers to provide ongoing funding for their employees' healthcare and follow an ongoing administrative scheme with extensive recordkeeping, reporting-and-disclosure and inspection dictates.

The Ordinance's expenditure rules cover "health care services" which are defined as including "medical care, services, or goods." That definition is virtually identical to ERISA section 3(1)'s definition of the benefits provided by an employee welfare benefit plan as including "medical, surgical, or hospital care or benefits." 29 U.S.C. § 1002(1). The Ordinance's expenditure rules apply to employers with twenty-or-more employees,[26] wherever located, so long as at

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[25] *See January* 2009 Status Report on the Implementation of the San Francisco Health Care Security Ordinance, 13.

[26] Employees are covered if they are employed for at least 90 days and perform at least 8 hours of work per week in San Francisco.

least one employee performs occasional work within the City.[27]

Employers have only two viable options to satisfy the mandate, both of which are ERISA-covered. The first is to establish their own health-plans, whether through group insurance or otherwise. Alternatively, under a "City-payment-option," employers may enroll their employees with the City and make quarterly-payments to the HAP. If eligible employees sign up for HAP, the employer contributions are allocated to them and reduce their participation fees by 75%.[28]

The Ordinance and City regulations impose a maze of ongoing administrative obligations, which are characteristic of "pay-or-play" laws. Among other administrative burdens, employers must differentiate hours worked by employees inside and outside of the jurisdiction; differentiate hours paid to "managerial," "supervisory" or "confidential" employees after making a discretionary determination on exemptions; track and report employment data for all companies in the same "controlled group," wherever located; differentiate and report health-expenditure amounts, including making annual-reports to the jurisdiction and quarterly-reports to individuals; and maintain sufficient documentation to prove that any reduction-

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[27] The 2009 rate is $1.23-per-hour for employers with 20-99 employees, and $1.86-per-hour for employers with 100-or-more employees.

[28] Eligible employees are City-residents who meet certain family-income-levels, have been uninsured for at least 90-days, are not eligible for public assistance and are between ages 18-and-64. For ineligible employees, the employer contributions fund health-savings-accounts which are ERISA-covered. Employee Benefits Security Administration, U.S. Department of Labor, Field Assistance Bulletin 2004-1 (Apr. 7, 2004).

in-force was not implemented to avoid the law's obligations. Non-compliance results in substantial daily administrative and civil penalties and attorney's fees and costs of enforcement.

If the Ninth Circuit's decision is allowed to stand, an employer with just 10 locations in different parts of the country could also easily face 10 different sets of such complex laws. An employer with 100 locations could face far more.

C. The District Court Proceeding

On November 8, 2006, Golden Gate filed a lawsuit in the District Court for the Northern District of California contending that ERISA bars the Ordinance's health-contributions mandate both through express and conflicts preemption. Golden Gate made four basic arguments.

First, as in *Fielder*, *supra*, ERISA preempts the contributions-mandate because it is, however artfully styled, an ERISA-preempted benefits-mandate. It requires employers to fund employee benefits for healthcare, and only healthcare, at set-minimum levels. It has an impermissible "connection with" ERISA plans because it interferes, in the same way as a benefits-mandate, with an employer's fundamental authority to decide whether to establish plans and to achieve cost-savings by setting nationally-uniform benefits, benefit levels and administrative practices.

Second, the Ordinance has an impermissible "connection with" ERISA plans *regardless* of the option chosen, because all of the options involve ERISA plans. Under the "City-payment-option," the employer establishes an ERISA plan for its employees in the same manner as it establishes an ERISA plan by paying group health-insurance premiums.

Third, even if the "City-payment-option" did not involve an ERISA plan, ERISA preempts the Ordinance because, as in *Fielder*, the law requires a "reference" to the employer's existing ERISA plan to see whether the required contribution levels are met.

Fourth, as in *Fielder*, ERISA preempts the Ordinance under conflicts preemption because it frustrates ERISA's objectives of an economical, voluntary plan system allowing nationally-uniform benefits, benefit levels and administrative practices.

On December 21, 2007, the District Court granted summary judgment to Golden Gate. The court held that the Ordinance has a prohibited "connection with" ERISA plans because its local requirements interfere with nationally-uniform plan administration; by mandating minimum-health expenditures, it regulates the types of benefits provided by ERISA plans; it imposes recordkeeping, inspection and other administrative burdens related to plan administration; and it makes unlawful reference to ERISA plans by requiring employers to modify plan administration or to structure additional payments by reference to amounts paid under existing plans. *Golden Gate Restaurant Association v. City and County of San Francisco*, 535 F.Supp.2d 968 (N.D.Cal. 2007). App. at 83a to 103a.

D. Ninth Circuit Stay, Opinion, and Order on Petition for Rehearing

On December 27, 2007, the City and several intervenors filed an emergency motion for stay of judgment with the Ninth Circuit's December 2007 motions panel. The motions panel, consisting of Judges Goodwin, W. Fletcher and Reinhart, granted the

stay.[29] Golden Gate petitioned to vacate the stay but, after ordering further briefing, Justice Kennedy declined to vacate the stay order.

The motions panel retained the case on the merits. The Secretary of Labor along with eight national entities filed *amicus* briefs supporting ERISA preemption.

On September 30, 2008, the Ninth Circuit reversed the District Court. The court held that a presumption against preemption applies because the Ordinance operates in an area of traditional state regulation; the Ordinance does not require employers to establish or to modify ERISA plans; the "City-payment-option" does not create an ERISA plan, because its administrative obligations do not involve an "ongoing administrative scheme" regulated by ERISA; and preemption is triggered by mandated-benefit laws, not by laws mandating contributions to pay for benefits. The court also declared that its holding does not conflict with *Fielder*, *supra*. *Golden Gate Restaurant Association v. City and County of San Francisco*, 546 F.3d 639 (9th Cir. 2008) ("*Golden Gate II*"). App. at 15a to 40a.

Golden Gate petitioned for rehearing *en banc*, again joined by *amici* including the Secretary of Labor who stated that the case involves a "recurring issue of exceptional importance." App. at 72a. Among other points, the Secretary argued that all options under the Ordinance involve ERISA plans and that *Golden Gate II* failed to apply properly the Supreme Court's ERISA preemption tests and reached a result inconsistent with *Fielder*, *supra*. App. at 72a to 81a.

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[29] *Golden Gate Restaurant Association v. City and County of San Francisco*, 512 F.3d 1112, 1119 (9th Cir. 2008).

On March 9, 2009, the Ninth Circuit denied rehearing. *Golden Gate Restaurant Association v. City and County of San Francisco*, 558 F.3d 1000 (9th Cir. 2009), App. at 41a to 61a. The order included a strong 11-page dissent joined by eight Judges, including Chief Judge Alex Kozinski.

The dissent described the case as involving "an issue of exceptional national importance." App. at 58a. "A currently non-complying employer in San Francisco," the dissent explained, "has the same choice as a non-complying employer in Maryland: Make a payment to the government or change its current ERISA plan." App. at 54a. The dissent added: "[p]er *Egelhoff*, a law like the San Francisco ordinance is ERISA-preempted because it frames employers' choices in this fashion." "Further," it wrote, "allowing San Francisco to pose such a choice would strike at the heart of ERISA because plan administrators would have to account for potential opt-out provisions in all 50 states." App. at 56a.

The dissent faulted the panel decision for creating a circuit split, rendering meaningless this Court's ERISA preemption tests in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983), and conflicting with other Supreme Court decisions. App. at 49a. It warned that the decision "will undoubtedly serve as a roadmap in jurisdictions across the country on how to design and enact a labyrinth of laws requiring employer compliance on health care expenditures, thereby creating the very kind of health care balkanization ERISA was intended to avoid." App. at 60a.

On March 30, 2009, Golden Gate's Application to Justice Kennedy to stay the mandate of the Ninth

Circuit pending petition for writ of certiorari was denied, after a request for further briefing.

REASONS FOR GRANTING THE PETITION

I. THE NINTH CIRCUIT HAS DECIDED AN IMPORTANT AND RECURRING ERISA PREEMPTION ISSUE IN DIRECT CONFLICT WITH THE FOURTH CIRCUIT.

Once again the Ninth Circuit has brought itself sharply into conflict with another circuit on an important, recurrent federal issue which requires uniformity nationwide. The decision creates a direct conflict among ERISA preemption holdings in the circuits which only this Court can resolve.

A. The Circuits are Clearly Divided on Whether ERISA Preempts "Pay-Or-Play" Laws

In *Fielder*, *supra*, the Fourth Circuit struck down Maryland's "fair-share" law, while the Ninth Circuit's *Golden Gate II* decision upheld San Francisco's "pay-or-play" law.

The circuit split is at ERISA's epicenter, the dividing line between federal and state-and-local powers. The "pay-or-play" and "fair-share" laws prohibit what ERISA permits.

ERISA preempts state and local laws if they conflict with "an area of core ERISA concerns" or its "principal goals."[30] ERISA's paramount concerns and goals include giving plan sponsors the autonomy to decide whether to offer employee benefits[31] and to

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[30] *Egelhoff*, 532 U.S. at 146-147.

[31] *Curtiss-Wright*, *supra*.

design and administer plans in a cost-effective, uniform national regulatory environment.[32] ERISA's purpose also includes ensuring that employers will not be put to "the choice of operating separate ongoing benefit plans or a single plan subject to different regulatory requirements." *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 16-17 (1987). Further, ERISA's purpose includes ensuring that plan sponsors and plans will not be required to "calculate benefit levels" differently from jurisdiction to jurisdiction.[33]

Maryland's "fair-share" law required employers of a certain size to spend at least 8% of their total payrolls on employees' health-insurance or to pay the shortfall to the state as a penalty. The Fourth Circuit framed its ERISA preemption holding on two bases.

The Fourth Circuit concluded that ERISA preempts the "fair-share" law as having an impermissible "connection with" ERISA plans, even if there were some "meaningful avenue" by which employers would incur non-ERISA health-spending. Compliance would have direct effects on the employers' ERISA plans. If employers attempted to use non-ERISA spending options, employers would need to coordinate those spending efforts with existing ERISA plans. The categories of ERISA and non-ERISA health-spending would not be isolated, unrelated costs for the employer. Decisions regarding one would impact the other. *Fielder*, 473 F.3d at 196-197.

Supporting this basis, the Fourth Circuit explained that Maryland law, coupled with a proliferation of similar laws, would constantly force employers to

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[32] *Shaw*, 463 U.S. at 105 n. 25; *Travelers*, 514 U.S. at 657-658; *Egelhoff*, *supra*.

[33] *Travelers*, 514 U.S. at 657-658.

monitor state-law developments and "manipulate heath care spending to comply with them," thereby conflicting with *Egelhoff*, *supra*. *Fielder*, 473 F.3d at 197. *Egelhoff held* that ERISA preempted a state law that operates to revoke the designation of a divorced spouse as a life insurance beneficiary, even though the plan could opt out by a simple plan amendment saying that the state law did not apply. The state law had an impermissible "connection with" plan administration by requiring plan administrators "to maintain a familiarity with the laws of all 50 States so that they can update their plans as necessary." 532 U.S. at 151. Citing *Egelhoff*, the Fourth Circuit held that a "state law that directly regulates the structuring or administration of an ERISA plan is not saved by inclusion of a means for opting out of its requirements." *Fielder*, 473 F.3d at 192.

The Fourth Circuit also concluded that ERISA preempts the law because it has an impermissible "connection with" ERISA plans by offering employers no reasonable choice but to increase contributions to their ERISA healthcare plans. The state would earmark employer shortfall payments for general-entitlement programs, thus conferring no benefit on the employees. Reasonable employers would not spend their money in that fashion. *Fielder*, 473 F.3d at 196.

In contrast, the Ninth Circuit held that ERISA preemption extends only to benefits-mandates, not to contributions-mandates, and the latter do not interfere with ERISA's goals including uniform plan administration within a single jurisdiction. App. at 41-43a, 37-48a. The court, however, refused to follow an essential step in this Court's preemption analysis: a consideration of the law's impact on uniform plan

administration for multistate plans and the potential for increased burdens if other jurisdictions enacted similar laws. *Egelhoff*, 532 U.S. at 151.

The Ninth Circuit attempted to distinguish *Fielder* on the ground that the Maryland statute offered the employer no reasonable choice but to increase its ERISA contributions. The Ordinance avoids preemption, the court concluded, because the "City-payment-option" results in a benefit for employees; hence, a rational employer might choose that option. App. at 45-46a. The court neither addressed nor attempted to distinguish the Fourth Circuit's holding that even if there were some meaningful choice for an employer, ERISA preempts the law because it requires employers to coordinate their ERISA spending with non-ERISA spending and constantly to monitor other laws.

The Ninth Circuit's decision is in clear conflict with the Fourth Circuit's decision. The Ninth Circuit's attempted distinction of the cases does not withstand scrutiny.

ERISA preemption does not rise or fall based on the relative attractiveness of options to creating or amending an ERISA plan. ERISA preempts a law if it conflicts with the Act's purposes by putting the employer to a choice of either restructuring its plan or plan administration, or opting out while keeping its eyes on other spending-mandates. *Egelhoff*, 532 U.S. at 151.

ERISA also preempts a law which forces employers to make choices—even rational ones—that would result in "different obligations in different states," since this by itself would defeat ERISA's stated goal of uniformity in plan administration. *Egelhoff*, 532 U.S. at

148. Moreover, even if an employer has what appears to be a "rational" opt-out choice of one government-administered health program, the choice is far from "rational" when the employer may have to confront "rational" choices in different states, cities and counties. As noted by the Secretary of Labor's *amicus* brief, "[e]ven if the administrative burden imposed by a single law may be tolerable, the cumulative burden could be staggering." App. at 91a.

Eight dissenting Ninth Circuit judges found that the panel decision's distinction based upon the reasonableness of the "City-payment-option" "conflicts" with *Fielder*. App. at 53a. The dissent also pointed out that the decision conflicts with ERISA preemption standards set forth in Supreme Court decisions including *Shaw*, *supra*, and *Egelhoff*, *supra*. App. at 61a, 57a. The dissent concluded that "[t]he holdings of *Fielder* and *Golden Gate* stand in clear opposition, and create a split on the issue of whether ERISA preempts 'fair-share' or 'pay-or-play' ordinances." App. at 54a-55a.

Swift intervention by this Court is essential. The Ninth Circuit's decision causes a circuit split destroying national uniformity in not only the voluntary nature of health-plans, but also in plan design, benefit levels and administration, the very factors which allow cost-effective plans. This split is certain to widen in the future as additional states, cities and counties, seeking to cut government spending in harsh economic times, enact "pay-or-play" laws based on new models including the San Francisco Ordinance. ERISA's objectives include the avoidance of "the possibility of endless litigation over the validity of

State action that might impinge on Federal regulation."[34]

Professor Edward A. Zelinsky has closely followed the circuit conflict on "pay-or-play" laws. Questioning the Ninth Circuit's unique benefits-versus-contributions distinction, he wrote: "Under [ERISA] Section 514(a), state law is preempted when it 'relate[s]' to employee benefit plans, not when it 'relate[s] to plan's outputs' ... If [the court's] approach does not trivialize the matter of ERISA preemption, it comes close." "At some point, it will be necessary for the Supreme Court to resolve the conflict represented by Fielder and Golden Gate II."[35]

B. The Issue Presented by the Conflict is Recurring and of Great National Importance

The conflict among the circuits on ERISA preemption of "pay-or-play" laws is both recurrent and of great national importance.

As of 2006, "pay-or-play" laws had already been proposed or were under consideration by at least thirty states as well as local jurisdictions across-the-country. Julia Contreras and Orly Lobel, "Wal-Martization and the Fair Share Health Care Acts," 19 St. Thomas L. Rev. 105, 136 (2006). Many of these proposals faced immediate opposition based on their being obviously-preempted by ERISA. The Ninth Cir-

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[34] Sen. Jacob K. Javits, 120 Cong. Rec. 29942 (1974).

[35] "Golden Gate Restaurant Association: Employer Mandates and ERISA Preemption in the Ninth Circuit," Cardozo Legal Studies Research Paper No. 19, pp. 22, 31; State Tax Notes, Vol. 47, 2008; available at SSRN: http://ssrn.com/abstract=1090122:

cuit's decision has clouded this formerly-clear issue, making future proposals far more likely to succeed.

The circuit conflict created by the Ninth Circuit cuts to the core of ERISA. At stake are two of ERISA's fundamental principles, both of national significance.

First, the circuit split over "pay-or-play" laws disrupts the national interest in encouraging the voluntary formation of employee benefit plans protected and governed by a single body of federal law.[36] Congress' goal was to "ensure that plans and *plan sponsors* would be subject to a uniform body of benefits law."[37] Employers' flexibility to adopt, modify, or terminate welfare benefit plans at any time[38] "is not an accident;" it was intended to encourage employers to set higher benefit levels at the outset (since they may be reduced if economic conditions sour) by streamlining administration and decreasing plan costs.[39] Congress carefully balanced this autonomy with employee-protection provisions that expressly prohibit interference with existing benefits, and require employers to follow a plan's written procedures prior to amendment.[40] These statutory protections ensure "that employers do not 'circumvent the provision of promised benefits.'"[41]

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[36] ERISA section 2(a), 29 U.S.C. § 1001(a).

[37] *Travelers*, 514 U.S. at 645 (emphasis added).

[38] *Curtiss-Wright Corp*, 514 U.S. at 78.

[39] *Inter-Modal Rail Employees Ass'n v. Atchison, Topeka & Santa Fe Ry.*, 520 U.S. at 510, 515 (1997).

[40] *Id.* at 515-516; ERISA sections 510 and 402(b)(3), 29 U.S.C. §§ 1140 and 1102(b)(3).

[41] *Inter-Modal*, 520 U.S. at 515 (citation omitted).

Second, the circuit conflict disrupts the national goal of "*minimiz[ing]* the need for interstate employers to administer their plans differently in each State." *Shaw*, 463 U.S. at 105 (emphasis added). Congress designed ERISA so that interstate employers could operate plans in a uniform, cost-efficient fashion, and be able "'to predict the legality of proposed actions without the necessity of reference to varying state laws.'"[42] The "basic thrust" of ERISA preemption is to "avoid a multiplicity of regulation in order to permit the nationally uniform administration" of employee benefits. *N.Y. State Conf of Blue Cross & Blue Shield Plans v. Travelers Ins. Co. ("Travelers")*, 514 U.S. 645, 657-658 (1995). As this Court observed in *Egelhoff*, 532 U.S. at 149-150, "[r]equiring administrators to master the relevant laws of 50 States and to contend with litigation would undermine the congressional goal of 'minimiz[ing] the administrative and financial burden[s]' on plan administrators—burdens ultimately borne by the beneficiaries."

The circuit conflict raised by *Golden Gate II* will cause widespread confusion and spur further litigation. It also politicizes the critical issue of uniformity in plan design, benefits and administration, allowing individual judges to impose their own social perspectives in an area where Congress has insisted upon allowing national uniformity. The decision reopens the door for the very multiplicity of federal, state and local regulation—coupled with multi-tiered, excessive administration costs—that brought about ERISA's enactment. Unless resolved, the conflict also will impede the prospect of successful national healthcare-reform.

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[42] *Pilot Life*, 481 U.S. at 56 (citation omitted).

This circuit conflict on a significant and recurring ERISA preemption issue of national consequence is alone sufficient ground for this Court's review.

II. THE NINTH CIRCUIT'S DECISION DIRECTLY CONFLICTS WITH SUPREME COURT DECISIONS HOLDING THAT ERISA PREEMPTS STATE LAWS MANDATING EMPLOYER CONTRIBUTIONS OR PLAN BENEFITS.

Still another reason supports the granting of a writ of certiorari. By creating a novel-but-unwarranted distinction between "mandated-contributions" and "mandated-benefits," the decision does violence to the Act's text and architecture, and directly conflicts with this Court's ERISA preemption decisions.

A. The Decision Renders Meaningless this Court's ERISA Preemption Standards in *Shaw v. Delta Air Lines* and Directly Conflicts With Other Supreme Court Preemption Decisions

The Ninth Circuit's decision effectively strips this Court's ERISA preemption standards in *Shaw*, *supra*, of any meaning. The decision also directly contradicts later decisions of this Court holding that ERISA preempts state laws mandating employer contributions or plan benefits.

ERISA's preemption clause—called the "crowning achievement of [the] legislation," 120 Cong. Rec. 29197 (Aug. 20, 1974), remarks of Rep. Dent—most clearly reflected Congress' effort to eliminate the threat of inconsistent or local regulation of employee benefit plans and establish in its stead a comprehensive and pervasive federal scheme. *Shaw*, 463 U.S. at 99.

ERISA's preemption clause states that the Act supersedes any and all state laws that "relate to" any employee benefit plan, with a state defined as including its political subdivisions. ERISA sections 514(a), (c)(2), 29 U.S.C. §§ 1144(a), (c)(2).

In *Shaw*, 463 U.S. at 96, this Court held that ERISA preempts a New York law that mandated pregnancy benefits because dictating such substantive terms would "relate to" an employee benefit plan within the meaning of 29 U.S.C. § 1144(a). The words "relate to" mean have "a connection with" or "reference to" ERISA plans. *Id.* at 97.

In *Travelers*, this Court explained that "[t]o determine whether a state law has the forbidden connection, we look both to 'the *objectives of the ERISA statute* as a guide to the scope of the state law that Congress understood would survive,' as well as to the nature and effect of the state law on ERISA plans." 514 U.S. at 656 (emphasis added) (citation omitted). Accordingly, ERISA preempts laws that touch on central areas of ERISA by "prohibit[ing]" what is "permitted" by federal law, "mandating employee benefit structures or their administration," or by "preclud[ing] uniform administrative practice." *Id.* at 656-657. In assessing the burden a law places on uniform administrative practices, this Court takes a far-ranging look consistent with ERISA's purposes. Under examination are the impact of the particular law on plan sponsors, plans and administrators, as well as the potential for increased burdens if similar laws were enacted by other states. *Egelhoff*, 532 U.S. at 151.

In formulating preemption standards, this Court has explained that ERISA's goal was to encourage employers to establish plans voluntarily and eco-

nomically through a single, federal regulatory system that allows uniform administrative practices across-the-nation. *Fort Halifax*, 482 U.S. at 12. In striking a balance between competing federal and state interests, ERISA makes plan regulation "'exclusively a federal concern.'" *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45-46 (1987)(citation omitted).

This Court has held that ERISA preempts state or local laws mandating employer contributions for group health-insurance, with a noncompliance penalty, *Agsalud*, *supra*; laws requiring plans to provide pregnancy benefits, *Shaw*, *supra*; and laws requiring employers to provide inactive employees, on workers' compensation, with the same health-benefits as active employees, *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125, 129-130 (1992).

The Ninth Circuit's contradiction of this Court's ERISA preemption holdings in *Golden Gate II* is direct and profound. ERISA preempts the San Francisco Ordinance because it creates the same national problems for plan sponsors, plans and ultimately the beneficiaries repeatedly highlighted by this Court's decisions, but doing so to a far-greater degree.

The Ordinance plainly violates the "connection with" prong of ERISA preemption. It compels employers to provide health-benefits to employees, a violation of ERISA's rule that employee benefit plans are to be completely voluntary. The Ordinance also compels employers to choose between maintaining uniformity in health-benefits through a required change in benefits in their existing ERISA plans, or giving up on uniformity through a required provision of different benefits to their San Francisco employees.

Further, an employer must adjust its administrative practices to reflect the Ordinance's unique administrative requirements including rules for coverage of part-time employees working as few as ten-hours-per-week, and for restricting a plan's ability to require employee contributions as part of a health-insurance program. Because employers may not count on "structuring administrative practices according to a set of uniform guidelines," they may "decide to reduce benefits or simply not to pay them at all" in some jurisdictions. *Fort Halifax*, 482 U.S. at 12.

The Ordinance also violates the "connection with" prong because the "City-payment-option" itself requires the creation of an ERISA plan, a point emphasized by the Secretary of Labor's *amicus* brief. App. at 85-86a. ERISA section 3(1) broadly defines an employee welfare benefit plan as including "*any plan, fund, or program*," "established or maintained by an employer," "for the purpose of providing for its participants ... through the *purchase of insurance or otherwise*, medical, surgical, or hospital care or benefits ...." 29 U.S.C. § 1002(1) (emphasis added). The test for ERISA plan coverage is a low-threshold one, designed to sweep as many plans as possible within ERISA's regulation. The test is simply whether the statutory requirements for a "plan, fund, or program" are met, not whether the employer designs the plan or performs all of the work. For example, the employer's day-to-day role in a standard, ERISA-covered group health-plan typically consists of paying premiums and handling a small amount of paperwork.[43] There is no employer-managed trust fund. An insurance

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[43] *See, e.g., Credit Managers Ass'n v. Kennesaw Life & Acc. Ins. Co.*, 809 F.2d 617 (9th Cir. 1987).

company, third-party administrator or PPO performs virtually all of the plan-design, administrative-and-fiduciary tasks, and payment functions. *See, e.g., Brundage-Peterson v. Compcare Health Services Ins. Co.*, 877 F.2d 509, 511 (7th Cir. 1989) ("The contingent feature of a true welfare benefit plan ... is unaffected by the delegation of the administrative duties of the plan to an insurance company—a delegation contemplated by the statute").

Under the "City-payment-option," an employer's ongoing contributions and regulatory compliance establish for its employees an ERISA health "plan, fund, or program" financed "through the purchase of insurance or otherwise." For ERISA's purposes, an employer's HAP-contributions are indistinguishable from its premium payments to an insurance company or a PPO for health-coverage, payments which result in an ERISA plan.[44] In each instance, the employees receive their benefits from a third-party professional administrator and the program is substantially administered by that party.

In concluding the "City-payment-option" was outside of ERISA, the Ninth Circuit contradicted the statute's plain text and Congress's goals. It made the unprecedented holding that for an ERISA plan to exist, not only must there be trust fund assets for ERISA to protect from employer mismanagement, but the employer itself must draft the plan's documents and perform the administrative and fiduciary duties. App. at 20a, 24-26a. This is a classical example of a theory which proves too much. Under this highly-restrictive coverage standard, very few if any

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[44] *See, e.g., Qualls v. Blue Cross of California*, 22 F.3d 839 (9th Cir. 1994).

insured health-plans, third-party-administered plans, or HMO or PPO plans would be governed by ERISA's rules and protections, and few ERISA plans would have professional plan administration.

The Ordinance also violates the "reference to" prong of ERISA preemption. An employer must determine its legal obligations by referring to its existing ERISA plans. This is precisely the situation which triggered preemption in *Washington Board of Trade*, *supra*. The District of Columbia ordinance made an impermissible "reference to" ERISA plans because it required equal health-benefits and therefore required a comparison to ERISA plans.

Similarly, ERISA preempts the Ordinance's healthcare contributions-mandate under *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990). ERISA preempts a claim if, in evaluating it, "the court's inquiry must be directed to the plan." *Id.* at 144. In any City-enforcement action, a court's inquiry must focus on the employer's ERISA plan to see whether it provides contributions equal to Ordinance levels.

B. The Decision's New ERISA Preemption Standard Improperly Allows Local Laws to Regulate Not Just Employer Contributions, But Employee Benefit Plans Themselves

The Ninth Circuit's decision invents an artificial, destructive ERISA preemption standard, one that undermines the Act's primary goals. If local governments may mandate employer contributions and complex administrative schemes, they may regulate ERISA plans themselves by first requiring their establishment and then dictating what benefits the plan provides, what categories of employees and part-

time workers are covered, and how the plan is administered. In addition, plan sponsors must constantly watch for diverse contribution-mandates and administrative regulations across-the-land.

The Ninth Circuit reached this anomalous result through an incorrect ERISA preemption analysis. The court started by observing that laws in areas historically regulated by the states enjoy "a presumption against preemption," citing *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 814 (1997), *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., NA., Inc.*, 519 U.S. 316, 330 (1997), and *Travelers*, *supra*.[45] App. at 13a. In each case, however, the state law was "remote from the areas with which ERISA is expressly concerned" and operated in "'areas where ERISA has nothing to say.'"[46] As applicable here, these cases reflect that ERISA preempts laws, even in areas of traditional local interests, if they have any one of the three features of the "pay-or-play" laws: forbid what ERISA permits, mandate plan structure or administration, or preclude uniform administrative-practices.[47]

The Ninth Circuit then inappropriately applied this presumption-against-preemption to the "pay-or-play" laws. As two other courts correctly concluded in *Fielder*, *supra*, and *Suffolk County*, *supra*, "pay-or-play" mandates aim directly at a quintessential rela-

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[45] *De Buono* simply held that ERISA does not preempt a gross-receipts-tax on healthcare-providers, while *Dillingham* rejected preemption of a prevailing-wage-law. *Travelers* rejected preemption of a surcharge-on-hospital-bills because it did not interfere with nationally-uniform plan administration.

[46] *Egelhoff*, 532 U.S. at 147-148.

[47] *E.g.*, *Travelers*, 514 U.S. at 656-658.

tionship ERISA was meant to govern exclusively: a plan sponsor's arrangements to pay for employees' "medical, surgical, or hospital care or benefits." 29 U.S.C. § 1002(1),

When reviewing mandates for employer contributions or for plan benefits, this Court has uniformly held them to be ERISA-preempted. *See, e.g., Agsalud, supra* (health insurance); *Shaw, supra* (pregnancy benefits); *Washington Board of Trade, supra* (health-benefits); *Stone & Webster Eng'g Corp. v. Ilsley*, 690 F.2d 323 (2d Cir. 1983) (same), *summarily aff'd*, 463 U.S. 1220 (1983). The Ninth Circuit has flatly refused to follow this controlling authority.

The Ninth Circuit based *Golden Gate II* not on the structure, language or purposes of ERISA, much less on this Court's carefully-developed preemption standards. Instead, the court premised its ERISA preemption standard on a spur-of-the-moment, unsupported theory, the type of judicial resolution described by this Court as "bring[ing] on stage, in classic fashion, a *deus ex machina* to extract from ... seemingly insoluble difficulties ... a happy ending."[48] Saving San Francisco's "pay-or-play" law, the Ninth Circuit held that preemption extends only to "mandated-benefits," not "mandated-contributions," and that the latter do not "interfere" with uniformity in plan administration, at least from the perspective of a purely local employer. App. at 35a, 36a-40a. This contributions-benefits distinction is not found anywhere in ERISA or in any prior court decision.

Most significantly, the Ninth Circuit's quixotic distinction between contributions-mandates and benefits-mandates clashes head-on with ERISA's

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[48] *Nevada v. Hicks*, 533 U.S. 353, 416 (2001).

plain text and the Act's principal objectives. It also defies common sense.

Nothing in ERISA's language or in any prior case supports the Ninth Circuit's view that Congress made an inexplicable decision that laws mandating employer contributions for employee benefits were exempt from preemption. 29 U.S.C. § 1144(a) preempts "*any and all*" laws that relate to employee benefit plans, not just some laws.

Employer contributions are not a tangential or peripheral matter, outside of ERISA's concerns. Employer contributions are an indispensable element of employer-financed ERISA plans, no less than gold bullion is to a gold coin. The Ninth Circuit's new contributions-benefits distinction is fanciful-but-illogical. It has a Cheshire-cat, *Alice-in-Wonderland* quality. There may a contribution without a benefit, but never a benefit without a contribution.

For ERISA preemption purposes, there is no material difference between laws mandating employee benefits and laws mandating contributions to pay for benefits. ERISA preempts a contributions-mandate because it overturns, in the same manner as a benefits-mandate, the Act's primary objectives of a voluntary system of cost-effective employee benefit plans[49] under which local laws do not "interfere with nationally uniform plan administration."[50]

Unless reversed, *Golden Gate II* will turn 29 U.S.C. § 1144(a) and this Court's preemption standards into a triviality, a mere semantics-game. A local government may avoid preemption simply by categoriz-

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[49] ERISA section 2(a), 29 U.S.C. § 1001(a)

[50] *Egelhoff*, 532 U.S. at 148.

ing a benefits-mandate as a contributions-mandate, with a government "healthcare-payment" penalty for noncompliance. For example, under the Ninth Circuit's preemption standard, a state may avoid the fate of the statute in *Shaw*, *supra*, by enacting a "contributions-mandate" for pregnancy benefits, coupled with a noncompliance-penalty relabeled a "healthcare-payment." As this Court explained in *Alessi*, 451 U.S. at 525, "ERISA's authors clearly meant to preclude the States from avoiding through form the substance of the pre-emption provision."

The Ninth Circuit's errors are two-fold. The decision allows "pay-or-play" laws to escape the conflicts preemption applicable to other federal statutes under the Supremacy Clause. At the same time, it makes ERISA's express preemption clause less forceful than conflicts preemption. This Court has already squarely rejected such a result in *Boggs v. Boggs*, 520 U.S. 833, 841 (1997) ("We can begin, and in this case end, the analysis by simply asking if state law conflicts with the provisions of ERISA or operates to frustrate its objectives"); *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 397 (2002) (THOMAS, J., dissenting) ("'formalist tricks cannot be sufficient to bypass'" ERISA preemption) (citation omitted).

Unless reversed, the Ninth Circuit's decision will overturn the voluntary nature of ERISA health-plans, remove them from exclusive federal governance, and preclude economical, nationally-uniform plan design, benefits and administration. These are among ERISA's core goals. The decision thus splits the central axis of this Court's ERISA preemption decisions.

C. The Decision Improperly Expands the Type of Government-Mandated Benefit Plans That Are Outside of ERISA's Safeguards

The Ninth Circuit's decision also warrants review because it improperly expands the types of government-mandated benefit plans that are outside of ERISA's safeguards. The decision will engender new confusion and litigation on a significant federal-state issue this Court has sought to resolve several times: under what circumstances do government-mandated benefits cause the creation of an ERISA-covered plan?

This Court has rejected the argument that "ERISA only pre-empts state regulation of pre-existing benefit plans established by the employer, and not state-mandated benefit plans." *Fort Halifax*, 482 U.S. at 16-17. Unless ERISA applied, such mandated-benefit laws would "afford employers a readily available means of evading ERISA's regulatory scope." *Id.* at 16.

For over two decades, this Court has consistently held that government-mandated payments of a type generally regulated by ERISA—such as severance-benefits—escape preemption *only* if the requirement does not create a continuing need to calculate and process the payments on an ongoing basis. *Fort Halifax*, *supra*, held that ERISA does not preempt a state's severance mandate applicable only to plant closures. The payment, a "one-time, lump-sum payment triggered by a single event," required "no administrative scheme whatsoever," while the statute "create[d] no impediment to an employer's adoption of a uniform benefit administration scheme." 482 U.S. at 12, 14.

Similarly, *Massachusetts v. Morash*, 490 U.S. 107, 115 (1989), held that a statute requiring an employer's payment of vacation pay to terminated employees did not create an ERISA plan because the payments, made out of the employer's own assets, were "typically fixed, due at known times, [did] not depend on contingencies outside the employee's control," and did not present risks different from the risk of non-payment of wages. In contrast, the Court explained, in ERISA-covered medical-care plans the benefits "accumulate over a period of time and are payable only upon a contingency outside of the control of the employee." 490 U.S. at 116.

San Francisco's "City-payment-option" involves the creation of an ERISA plan and triggers ERISA preemption because it does far more than require a mere payroll-practice such as cutting a check. All of the Ordinance's options impose ongoing employer payment requirements coupled with a phalanx of administrative chores. As noted in the Secretary of Labor's *amicus* brief, these are precisely the type of administrative requirements that bring a state mandated-benefit plan within ERISA. App. at 87a.

III. THE QUESTION PRESENTED BY THIS PETITION IS ONE OF EXCEPTIONAL NATIONAL IMPORTANCE THAT SHOULD BE ADDRESSED BY THIS COURT.

This Court should review the Ninth Circuit's decision not only because it creates a significant circuit conflict and directly contradicts this Court's ERISA preemption decisions, but also because it raises an issue of exceptional national importance at a time of intensified efforts at federal healthcare-reform. At stake is whether the federal government, or state-and-local powers, will regulate the nation's employee benefit plan system. Unless reversed, the decision will have far-ranging repercussions on this issue and ERISA's most basic objectives.

With the force of a broad-ax, *Golden Gate II* severs ERISA's preemption provision from the Act's principal goals. These include a voluntary employee benefit plan system nationwide whose uniformity and cost-efficiencies are protected by federal law. Simultaneously, the decision uproots well-settled understandings of what constitutes an ERISA plan.

The Ninth Circuit's decision surrenders to the states and countless local municipalities a largely free-rein over the sphere of employee benefit plans. If left standing, the decision will mark the return to a costly, inefficient era when plans were subject to control by fifty different sets of state-law rules and subsets of local regulations. It will resurrect the same obstacles to plan growth and development—the "multiplicity of regulation" and "'conflicting directives'"[51]—that Congress sought to end through ERISA.

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[51] *Travelers*, 514 U.S. at 656-657 (citation omitted).

The employee benefit plan landscape will become far more hostile than before ERISA. While plans and plan sponsors will remain subject to comprehensive ERISA regulation, federal rules will be overlaid with mandates for establishing health-plans and administering them pursuant to conflicting, overlapping and ever-changing state and local regulations. In short time, excessive administration-compliance costs will deplete the employer funds available for benefits, to the detriment of employers and employees alike.

The practical implications of *Golden Gate II* are staggering. As of 2006, healthcare spending totaled approximately 16% of the gross domestic product.[52] Employer-related group health-insurance covers an estimated 177 million individuals.[53] More than nine-out-of-ten employers offer PPO-options and nearly four-out-of-ten offer HMO-options.[54] Unless the decision is reversed, all of these insured group plans, plans with PPO or HMO-options, and self-funded plans with third-party administrators may be subject to "pay-or-play" laws. At the same time, *Golden Gate II*'s highly-restrictive standard for ERISA plan coverage will place the great bulk of these economical off-the-shelf plans outside of ERISA's protections. Further, employers will be able to avoid ERISA's fiduciary duty rules and its civil and criminal enforcement provisions merely by hiring a third-party to perform the bundle of plan-design and administrative-and-fiduciary tasks inherent in any plan. It is difficult to conceive of any law or any

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[52] STATISTICAL ABSTRACT OF THE UNITED STATES: 2009, 96 (128th ed.).

[53] *Id.* at 105.

[54] *Id.* at 24.

decision causing greater damage to the nation's employee benefit plan system.

The nation's vast size makes the problems caused by *Golden Gate II* intolerable. In addition to 50 states, there are over 3,000 counties and more than 35,000 cities and towns.[55] The Ninth Circuit's decision will expose sponsors of multistate plans to a prohibitively-expensive situation: a patchwork-quilt of mandates and regulations coast-to-coast. A single local jurisdiction's power to regulate employee benefit plans becomes the power to overwhelm and destroy the national system of plans if wielded by a series of jurisdictions. This is the same insurmountable burden posed by the earlier influx of state-by-state experiments with employer mandates—dating back to the Hawaii Prepaid Health Care Act—that gave rise to ERISA's broader-than-originally-proposed preemption clause.

If *Golden Gate II* is allowed to stand, sponsors will not be able to establish employee benefit plans voluntarily, much less on an efficient company-wide or nation-wide basis. Instead, they must set up plans and allocate health-expenditures on a haphazard, inefficient person-by-person, location-by-location basis. Sponsors must constantly monitor for new laws in all jurisdictions. There will be a bewildering mismatch of employer contribution rules, either by percentage-of-gross-payroll or a dollar-amount-per-hour-worked. The varying contribution levels themselves may move upwards at uneven rates. Different jurisdictions may require coverage of different categories of employees and part-time workers, and impose different employee contribution requirements or deductibles and

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[55] *Id.* at 259.

co-payments. Compliance with varying employer-contribution formulas and data-compilation and administrative rules will overload the largest human resources departments and the most expensive software-systems.

The Ninth Circuit's decision—coupled with the circuit conflict over ERISA preemption—will also create enormous confusion and difficulty in the design and administration of thousands of employee benefit plans nationwide. Plan sponsors need to know whether they may create plans without fear that a nationally-uniform set of benefits and administrative practices will be overturned in one jurisdiction or another by an unduly-restrictive application of ERISA preemption. It will be impossible for sponsors to predict or even identify the "'uniform body'" of federal benefits law, which is a "basic thrust" of ERISA.[56] Sponsors will not even know which diverging sets of federal and state or local laws to apply in establishing and administering their plans.

This cliff-edge departure from the national uniformity of law required by ERISA, the chaos in plan administration, and the steeply-increased transaction costs will require sponsors to reduce benefits or compensation overall or to eliminate some plans altogether, *Fort Halifax*, 482 U.S. at 13, contrary to the "public interest in encouraging the formation of employee benefit plans," *Pilot Life*, 481 U.S. at 54. None of this promotes the "national public interest" in a voluntary system of employee benefit plans. None of this protects the cost-efficiencies which lie at ERISA's core. None of this furthers ERISA's goals.

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[56] *Travelers*, 514 U.S. at 656-657.

Moreover, the rationale of the Ninth Circuit's decision—that ERISA only preempts mandated-benefits, not mandated-contributions – extends beyond health-benefits. It includes welfare benefits of every stripe. Additionally, states, cities and counties face responsibilities for older residents, many of whom are low-income and may lack significant pensions. If local governments may mandate ongoing employer contributions and administrative schemes for health-benefits, presumably they may also mandate similar ones for pension benefits. Through these devices, local governments may effectively require multistate employers to follow each jurisdiction's unique dictates for establishing and administering ERISA plans providing pension and welfare benefits. All of this is at direct odds with the structure, logic and purpose of ERISA and three decades of Supreme Court precedent.

Swift intervention by this Court is critical to restore the carefully-crafted balance between state and federal law struck by Congress in ERISA and to reestablish the preeminence of ERISA's statutory scheme. Given the "centrality of pension and welfare plans in the national economy," *Boggs v. Boggs*, 520 U.S. at 839, it is vital that this Court decide the significant, far-reaching ERISA preemption issue presented by this case, and resolve the existing circuit conflict.

CONCLUSION

For the foregoing reasons, petitioner urges the Court to grant a writ of certiorari in this case.

Respectfully submitted,

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APPENDIX

APPENDIX A

FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 07-17370
D.C. No. CV-06-06997-JSW

GOLDEN GATE RESTAURANT, ASSOCIATION,
an incorporated non-profit trade association,
Plaintiff-Appellee,

v.

CITY AND COUNTY OF SAN FRANCISCO,
Defendant,

SAN FRANCISCO CENTRAL LABOR COUNCIL;
SERVICE EMPLOYEES INTERNATIONAL UNION,
HEALTHCARE WORKERS-WEST;
SERVICE EMPLOYEES INTERNATIONAL UNION,
LOCAL 1021; UNITE HERE LOCAL 2,
Defendant-intervenors-Appellants

No. 07-17372
D.C. No. CV-06-06997-JSW OPINION

GOLDEN GATE RESTAURANT, ASSOCIATION,
an incorporated non-profit trade association,
Plaintiff-Appellee,

v.

CITY AND COUNTY OF SAN FRANCISCO,
Defendant,

SAN FRANCISCO CENTRAL LABOR COUNCIL;
SERVICE EMPLOYEES INTERNATIONAL UNION,
HEALTHCARE WORKERS-WEST;
SERVICE EMPLOYEES INTERNATIONAL UNION,
LOCAL 1021; UNITE HERE LOCAL 2,
Defendant-intervenors-Appellants.

Appeal from the United States District Court
for the Northern District of California
Jeffrey S. White, District Judge, Presiding

Argued and Submitted
April 17, 2008—Pasadena, California

Filed September 30, 2008

OPINION

Before: Alfred T. Goodwin, Stephen Reinhardt, and William A. Fletcher, Circuit Judges.

Opinion by Judge William A. Fletcher

W. FLETCHER, Circuit Judge:

Plaintiff Golden Gate Restaurant Association ("the Association") challenges the employer spending requirements of the newly enacted San Francisco Health Care Security Ordinance ("the Ordinance"). The Association argues that the federal Employee Retirement Income Security Act of 1974 ("ERISA") preempts the employer spending requirements of the Ordinance either because those requirements create a "plan" within the meaning of ERISA or because they "relate to" employers' ERISA plans. On December 26, 2007, the district court granted the Associa-

tion's motion for summary judgment and enjoined the implementation of the employer spending requirements. *Golden Gate Rest. Ass'n v. City & County of San Francisco*, 535 F. Supp. 2d 968, 970 (N.D. Cal. 2007). On December 27, 2007, Defendant City and County of San Francisco ("the City") and Defendant-Intervenor labor unions requested that this court stay the judgment of the district court pending appeal. In an order filed January 9, 2008, we granted the stay. *Golden Gate Rest. Ass'n v. City & County of San Francisco* ("*Golden Gate*"), 512 F.3d 1112, 1114 (9th Cir. 2008). We now reach the merits of the appeal. We hold that ERISA does not preempt the Ordinance.

I. Procedural History

In July 2006, the San Francisco Board of Supervisors unanimously passed the San Francisco Health Care Security Ordinance, and the mayor signed it into law. The Ordinance is codified at Sections 14.1 to 14.8 of the City and County of San Francisco Administrative Code. The Ordinance has two primary components: the Health Access Plan ("HAP"), and the employer spending requirements. The HAP[1] is a City-administered health care program. It went into effect in the summer of 2007. In funding the HAP, the City "prioritize[s] services for low and moderate income persons." S.F. Admin. Code § 14.2(d) (2007). According to the City's web page, as of August 9, 2008, 27,395 persons had enrolled in the HAP.[2] Persons who already have health insurance or who live outside of San Francisco are not eligible for the HAP.

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[1] The HAP is now called "Healthy San Francisco."

[2] Healthy San Francisco, about Us, http://www.healthysanfrancisco.org/about_us/Stats.aspx#

Instead, such persons may be entitled to establish medical reimbursement accounts with the City. As we will explain in detail below, the Ordinance also requires all covered employers to make a certain level of health care expenditures on behalf of their covered employees. The Association does not challenge the HAP. It challenges only the employer spending requirements.

The Association filed a complaint against the City on November 8, 2006, asking the district court to declare that ERISA preempts the employer spending requirements, and seeking a permanent injunction against enforcement of the provisions of the Ordinance relating to those requirements. The San Francisco Central Labor Council, Service Employees International Union (SEIU) Local 1021, SEIU United Healthcare Workers-West, and UNITE-HERE! Local 2 (collectively, "Intervenors"), successfully moved to intervene as defendants.

On April 2, 2007, the City deferred implementation of the employer spending requirements until January 1, 2008. On July 13, 2007, the parties filed cross-motions for summary judgment. On December 26, 2007, the district court entered judgment for the Association, concluding that ERISA preempts the employer spending requirements. *See Golden Gate Rest. Ass'n*, 535 F. Supp. 2d at 979-80.

On December 27, 2007, the City and Intervenors asked the district court to stay its judgment pending appeal. The district court denied the motion. On January 9, 2008, this court filed a published order granting the City's motion for a stay of the district court's judgment pending resolution of the City's appeal. *Golden Gate*, 512 F.3d at 1127. Since that

date, covered employers have been required to make quarterly health care expenditures.

On February 7, 2008, the Association filed an application with Justice Kennedy, as Circuit Justice for the Ninth Circuit, for an order vacating our stay of the district court's judgment. On February 21, after receiving the City's response, Justice Kennedy denied the application. The United States Secretary of Labor subsequently filed an *amicus* brief in this court in support of the Association.

On April 17, 2008, we heard oral argument on the merits of the City's appeal. We now reverse the judgment of the district court and remand with instructions to enter summary judgment in favor of the City and Intervenors.

II. Standard of Review

"We review *de novo* the district court's grant of summary judgment and, viewing the evidence in the light most favorable to the non-moving party, determine whether there are any genuine issues of material fact for trial." *In re Syncor ERISA Litig.*, 516 F.3d 1095, 1100 (9th Cir. 2008). "ERISA preemption is a question of law, which we also review *de novo*." *Elliot v. Fortis Benefits Ins. Co.*, 337 F.3d 1138, 1141 (9th Cir. 2003).

III. The Ordinance

The Ordinance mandates that covered employers make "required health care expenditures to or on behalf of certain employees each quarter. S.F. Admin. Code § 14.3(a). "Covered employers" are employers engaging in business within the City that have an average of at least twenty employees performing work for compensation during a quarter, and non-

profit corporations with an average of at least fifty employees performing work for compensation during a quarter. *Id.* § 14.1(b)(3), (11), (12). "Covered employees" are individuals who (1) work in the City, (2) work at least ten hours per week, (3) have worked for the employer for at least ninety days, and (4) are not excluded from coverage by other provisions of the Ordinance. *Id.* § 14.1(b)(2).

The Ordinance sets the required health care expenditure for employers based on the Ordinance's "health care expenditure rate." *Id.* §§ 14.1(b)(8), 14.3(a). For-profit employers with between twenty and ninety-nine employees and non-profit employers with fifty or more employees must make health care expenditures at a rate of $1.17 per hour. For-profit employers with one hundred or more employees must make expenditures at a rate of $1.76 per hour. *See* City & County of San Francisco, Office of Labor Standards Enforcement, Regulations Implementing the Employer Spending Requirement of the San Francisco Health Care Security Ordinance ("ESR"), Reg. 5.2(A) (2007).[3] Under the Ordinance, "[t]he required health care expenditure for a covered employer shall be calculated by multiplying the total number of hours paid for each of its covered employees during the quarter . . . by the applicable health care expenditure rate." S.F. Admin. Code § 14.3(a).

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[3] On June 16, 2008, the City issued revised ESR regulations. Those revisions do not pertain to any of the regulations discussed in this opinion. *See* City & County of S.F. Office of Labor Standards Enforcement, Regulations Implementing the Employer Spending Requirement of the San Francisco Health Care Security Ordinance (June 16, 2008), *available at* http://www.sfgov.org/site/uploadedfiles/olse/hcso/ HCSO Final Regulations.pdf.

Regulations implementing the Ordinance specify that "[a] health care expenditure is any amount paid by a covered employer to its covered employees or to a third party on behalf of its covered employees for the purpose of providing health care services for covered employees or reimbursing the cost of such services for its covered employees." ESR Reg. 4.1(A). A "covered employer has discretion as to the type of health care expenditure it chooses to make for its covered employees." ESR Reg. 4.2(A). Section 14.1(b)(7) of the Ordinance specifies that the definition of health care expenditure includ[es], but [is] not limited to

> (a) contributions by [a covered] employer on behalf of its covered employees to a health savings account as defined under section 223 of the United States Internal Revenue Code or to any other account having substantially the same purpose or effect without regard to whether such contributions qualify for a tax deduction or are excludable from employee income;
>
> (b) reimbursement by such covered employer to its covered employees for expenses incurred in the purchase of health care services;
>
> (c) payments by a covered employer to a third party for the purpose of providing health care services for covered employees;
>
> (d) costs incurred by a covered employer in the direct delivery of health care services to its covered employees; and
>
> (e) payments by a covered employer to the City to be used on behalf of covered employees. The City may use these payments to:

> (i) fund membership in the Health Access Program for uninsured San Francisco residents; and
>
> (ii) establish and maintain reimbursement accounts for covered employees, whether or not those covered employees are San Francisco residents.

S.F. Admin. Code § 14.1(b)(7) (paragraphing added); *see also* ESR Reg. 4.2(A).

If an employer does not make required health care expenditures on behalf of employees in some other way, it may meet its spending requirement by making payments directly to the City under § 14.1(b)(7)(e). *See* ESR Reg. 4.2(A). We refer to this option as the City-payment option. If an employer elects the City-payment option, its covered employees who satisfy age and income requirements and are "uninsured San Francisco residents" may enroll in the HAP, and its other covered employees will be eligible for medical reimbursement accounts with the City. Covered employees may enroll in the HAP free of charge or at reduced rates. The HAP provides enrollees with "medical services with an emphasis on wellness, preventive care and innovative service delivery." S.F. Admin. Code § 14.2(f). A primary care provider at the enrollee's "medical home" "develop[s] and direct[s] a plan of care for each [HAP] participant." *Id.* § 14.2(e). Enrollees pay income-based "participation fees" and "point-of-service fees." Regulations Implementing Health San Francisco and Medical Reimbursement Account Provisions of the San Francisco Health Care Security Ordinance, Reg. 4(a) (2007).

An employer is exempt from making payments to the City if it makes health care expenditures under

§ 14.1(b)(7)(a)-(d) of at least $1.17 or $1.76 per hour (depending on the nonprofit or for-profit status of the employer, and on the number of employees), and it is partially exempt to the extent that it makes lesser expenditures.

The Ordinance requires covered employers to "maintain accurate records of health care expenditures, required health care expenditures, and proof of such expenditures made each quarter each year," but it does not require them "to maintain such records in any particular form." S.F. Admin. Code § 14.3(b)(i). Employers must provide the City with "reasonable access to such records." *Id.* If an employer fails to comply with these requirements, the City will "presume[ ] that the employer did not make the required health expenditures for the quarter for which records are lacking, absent clear and convincing evidence otherwise." *Id.* § 14.3(b)(ii).

The Ordinance includes a special provision for employers with self-insured health plans. An employer providing "health coverage to some or all of its covered employees through a self-funded/self-insured plan" will "comply with the spending requirement . . . if the preceding year's average expenditure rate per employee meets or exceeds the applicable expenditure rate" for the employer. ESR Reg. 6.2(B)(2). Such employers do not need to keep track of their actual expenditures for each employee.

Relevant to our analysis, there are five categories of employers under the Ordinance. First are employers that have no ERISA plans ("No Coverage Employers"). Second are employers that have ERISA plans for all employees, and that spend at least as much as the Ordinance's required health care expenditure per employee ("Full High Coverage

Employers"). Third are employers that have ERISA plans for some, but not all, employees, and that spend at least as much as the Ordinance's required health care expenditure per employee for employees under the ERISA plan ("Selective High Coverage Employers"). Fourth are employers that have ERISA plans for all employees, but that spend less than the Ordinance's required health care expenditure per employee ("Full Low Coverage Employers"). Fifth are employers that have ERISA plans for some, but not all, employees, and that spend less than the Ordinance's required health care expenditure per employee for employees under the ERISA plan ("Selective Low Coverage Employers").

No Coverage Employers may choose to continue without any ERISA plans. In that event, they can make their required health care expenditures directly to the City. *See* ESR Reg. 4.2(A)(6). If these employers choose, instead, to establish an ERISA plan, the Ordinance requires only that they make the required level of health care expenditures. They can do so by paying the full amount to the plan, or by paying part to the plan and part to the City. The Ordinance does not dictate which employees must be eligible for the plan, or what benefits a plan must provide. *See* ESR Reg. 4.2(A)(1)-(5).

Full High Coverage Employers may choose to leave their ERISA plans intact and unaltered. So long as they maintain records to show that they are making the required health care expenditures, they comply with the Ordinance.

Selective High Coverage Employers may choose to leave their ERISA plans intact and unaltered. In that event, for employees not covered by their ERISA plans, they can comply with the Ordinance by mak-

ing the required health care expenditures to the City. *See* ESR Reg. 6.2(C) ("An employer may . . . choose to purchase health insurance for its full-time employees, but make payment to the City to fund part-time employees' membership in the Health Access Program[.]").

Full Low Coverage Employers may choose to leave their ERISA plans intact and unaltered. In that event, they can comply with the Ordinance by making payments to the City in an amount equal to the difference between their expenditures for the ERISA plans and the required health care expenditures under the Ordinance. *See* ESR Reg. 6.2(D) ("[A]n employer who purchases a health insurance program with premiums that are less than the required expenditure . . . may choose to pay the remainder to the City to establish and maintain medical reimbursement accounts for such employees.").

Selective Low Coverage Employers may choose to leave their ERISA plans intact and unaltered. In that event, they can comply with the Ordinance for employees enrolled in their ERISA plans by paying to the City the difference between their expenditures for the plans and the required health care expenditures under the Ordinance, and for employees not enrolled in their ERISA plans by paying to the City the full amount of the required health care expenditures.

We make two observations about the Ordinance. First, the Ordinance does not require employers to establish their own ERISA plans or to make any changes to any existing ERISA plans. Employers may choose to make up the difference between their existing health care expenditures and the minimum expenditures required by the Ordinance either by altering existing ERISA plans or by establishing new

ERISA plans. However, they need not do so. The City-payment option allows employers to make payments directly to the City, if they so choose, without requiring them to establish, or to alter existing, ERISA plans. If employers choose to pay the City, the employees for whom those payments are made are entitled to receive either discounted enrollment in the HAP or medical reimbursement accounts with the City.

Second, the Ordinance is not concerned with the nature of the health care benefits an employer provides its employees. It is only concerned with the dollar amount of the payments an employer makes toward the provision of such benefits. An employer can satisfy its spending requirements by paying the City; it can satisfy those requirements by funding exclusively preventive care; it can satisfy those requirements by setting up an on-site clinic and reimbursing employees for the purchase of over-the-counter medications; or it can satisfy those requirements in some other manner, such as funding a traditional ERISA plan. The Ordinance does not look beyond the dollar amount spent, and it does not evaluate benefits derived from those dollars.

IV. Discussion

The Association argues that ERISA preempts the Ordinance either because it creates a "plan" within the meaning of ERISA or because it "relates to" employers' ERISA plans within the meaning of ERISA. For the reasons that follow, we disagree.

Crafted as a compromise between employers and employees, ERISA has two primary purposes. First, from the perspective of employees and other beneficiaries of ERISA plans, "ERISA was passed by Con-

gress in 1974 to safeguard employees from the abuse and mismanagement of funds that had been accumulated to finance various types of employee benefits." *Massachusetts v. Morash*, 490 U.S. 107, 112 (1989). "In enacting ERISA, Congress' primary concern was with the mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits from accumulated funds. To that end, it established extensive reporting, disclosure, and fiduciary duty requirements to insure against the possibility that the employee's expectation of the benefit would be defeated through poor management by the plan administrator." *Id.* at 115 (citation and footnote omitted). Second, from the perspective of employers, "[t]he purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004). Uniformity of regulation eases the administrative burdens on employers and plan administrators, thereby reducing costs to employers.

A. Presumption Against Preemption

We begin by noting that state and local laws enjoy a presumption against preemption when they "clearly operate[ ] in a field that has been traditionally occupied by the States." *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 814 (1997) (internal quotation marks omitted). This presumption informs our preemption analysis. *See Boggs v. Boggs*, 520 U.S. 833, 840 (1997) (the fact that a state law "implement[s] policies and values lying within the traditional domain of the States . . . inform[s] [a] preemption analysis"). The presumption against preemption applies in ERISA cases. "[N]othing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general

health care regulation, which historically has been a matter of local concern." *N. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 661 (1995). "[T]he Court has established a presumption that Congress did not intend ERISA to preempt areas of traditional state regulation that are quite remote from the areas with which ERISA is expressly concerned—reporting, disclosure, fiduciary responsibility, and the like." *Rutledge v. Seyfarth, Shaw, Fairweather & Gerald. von*, 201 F.3d 1212, 1217 (9th Cir. 2000) (emphasis in original; internal quotation marks omitted). Further, "ERISA preemption must have limits when it enters areas traditionally left to state regulation—such as the state's . . . regulation of health . . . matters." *Operating Eng'rs Health & Welfare Trust Fund v. JWJ Contracting Co.*, 135 F.3d 671, 677 (9th Cir. 1998).

The field in which the Ordinance operates is the provision of health care services to persons with low or moderate incomes. State and local governments have traditionally provided health care services to such persons. *See* Paul Star, *The Social Transformation of American Medicine* 185 (1982) (noting that other than the four-year period from 1879 to 1883, when there was a National Board of Health, "public health remained almost entirely a state and local responsibility"); *id.* at 181-82 (describing "the role of public dispensaries in treating the sick poor"); *id.* at 169 (describing the first phase of the hospital system in the United States, spanning 1751 to 1850, in which there were charitable hospitals "and public hospitals, descended from almshouses and operated by municipalities [and] by counties"); *id.* at 171 (noting that "[p]ublic hospitals generally treated the poor [and] relied on government appropriations rather than fees"). The Ordinance uses a novel

approach to the provision of health services to such persons, but operates in a field that has long been the province of state and local governments, thereby "implement[ing] policies and values lying within the traditional domain of the States." *Boggs*, 520 U.S. at 840.

B. Preemption Under ERISA

ERISA governs "employee benefit plans," including "employee welfare benefit plans." 29 U.S.C. § 1002(3). Section 514(a) of ERISA states that ERISA preempts "any and all State laws insofar as they . . . relate to any employee benefit plan" governed by ERISA. 29 U.S.C. § 1144(a). "A law 'relate[s] to' a covered employee benefit plan for purposes of § 514(a) if it [1] has a connection with or [2] reference to such a plan." *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., NA., Inc.* ("*Dillingham*"), 519 U.S. 316, 324 (1997) (alterations in original; some internal quotation marks omitted).

The Association and the amicus, the Secretary of Labor, make two central arguments. First, they argue that the City-payment option under the Ordinance creates an ERISA plan. This argument takes two forms. The Association argues in its brief that the Ordinance's administrative obligations on employers, in combination with a reasonable person's ability to ascertain "benefits, beneficiaries, source of financing, and procedures for receiving benefits," creates an ERISA plan. The Secretary of Labor argues as amicus that the HAP itself is an ERISA plan. If either argument is correct, the Ordinance almost certainly makes an impermissible "reference to" an ERISA plan. Second, they argue that even if the City-payment option does not establish an ERISA plan, an employer's obligation to make payments at a

certain level—whether or not the payments are made to the City—"relates to" the ERISA plans of covered employers and is thus preempted. We address these arguments in turn.

1. The City Payment Option Does Not Create an ERISA "Plan"

If the City-payment option does not create an "employee welfare benefit plan" within the meaning of ERISA, the first argument fails. The district court concluded that employers' payments to the City do not create an ERISA plan. *See Golden Gate Rest. Ass'n*, 535 F.Supp. 2d at 976 (Ordinance does not "create[ ] a separate *de facto* ERISA plan"). For the reasons that follow, we agree with the district court and hold that the City-payment option does not create an ERISA plan, *de facto* or otherwise. We first address the Association's argument. We then address the Secretary's argument.

a. Employers' Administrative Obligations, and the Ability to Ascertain Benefits, Beneficiaries, Financing and Procedures

The first element of an employee welfare benefit plan is the existence of a "plan, fund or program." *Patelco Credit Union v. Sahni*, 262 F.3d 897, 907 (9th Cir. 2001). In the context of ERISA, the phrase "plan, fund or program" is a term of art. As relevant to this case, an ERISA "plan" is an "employee welfare benefit plan," defined as

> [a]ny plan, fund, or program which . . . is . . . established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the pur-

> pose of providing for its participants . . . , through the purchase of insurance or otherwise, . . . medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment . . .

29 U.S.C. § 1002(1); *see also* § 1002(3); *Patelco Credit Union*, 262 F.3d at 907.

> The Supreme Court has emphasized that ERISA is concerned with "benefit plans," rather than simply "benefits," because "[o]nly 'plans' involve administrative activity potentially subject to employer abuse." *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 16 (1987). This focus on "benefit plans" is consistent with the first underlying purpose of ERISA — protecting employees against the abuse and mismanagement of funds. If an employee's expectation of a "benefit" presents "a danger of defeated expectations [that] is no different from the danger of defeated expectations of wages for services performed," then the employer's actions giving rise to that expectation do not amount to a "benefit plan" because such danger is one "Congress chose not to regulate in ERISA." *Morash*, 490 U.S. at 115.

Two Supreme Court cases tell us that an employer's obligation to make monetary payments based on the amount of time worked by an employee,

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over and above ordinary wages, does not necessarily create an ERISA plan. This is so even if the payments are made by the employer directly to the employees who are the beneficiaries of the putative "plan." First, in *Fort Halifax*, a Maine statute required an employer to pay employees one week's pay for every year worked if the employees were terminated because of a plant closing. The Court held that the statute did not create a "plan" within the meaning of ERISA: "The Maine statute neither establishes, nor requires an employer to maintain, an employee benefit *plan*. The requirement of a onetime, lump-sum payment triggered by a single event requires no administrative scheme whatsoever to meet the employer's obligation." *Id.* at 12.

Second, in *Massachusetts v. Morash*, 490 U.S. 107, 109 (1989), a Massachusetts statute required employers to pay discharged employees their "full wages, including holiday or vacation payments, on the date of discharge." The Court held that the statute was not preempted by ERISA. The Court wrote, "It is unlikely that Congress intended to subject to ERISA' s reporting and disclosure requirements those vacation benefits which by their nature are payable on a regular basis from the general assets of the employer and are accumulated over time only at the election of the employee." *Id.* at 116. The Court in *Morash* emphasized the importance of the fact that the employer made the payments out of its general assets:

> An entirely different situation would be presented if a separate fund had been created by a group of employers to guarantee the payment of vacation benefits to laborers who regularly shift their jobs from one employer to another. Em-

> ployees who are beneficiaries of such a trust face far different risks and have far greater need for the reporting and disclosure requirements that the federal law imposes than those whose vacation benefits come from the same fund from which they receive their paychecks.

Id. at 120.

The employer payments at issue under the San Francisco Ordinance, which the Association contends create an ERISA plan, are not made directly to employees. Rather, they are made to the City. But even if the employers made the payments directly to the employees, *Fort Halifax* and *Morash* indicate that those payments would not be enough to create an ERISA plan. Under the Ordinance, employers make the payments on a regular periodic basis and calculate those payments based on the number of hours worked by the employee. Further, as in *Morash*, employers make the payments "on a regular basis from [their] general assets." If employers made the payments directly to the employees, there would be little to differentiate those payments from wages paid to employees. Indeed, the City allows employers to pay the City on a weekly, bi-weekly, or monthly basis, so that employers may coordinate their payments under the Ordinance with their employees' regular pay periods. *See* ESR Reg. 6.2(A)(2).

The fact that an employer makes its payments to the City rather than to the employees confirms, if confirmation were needed, that the employer's administrative obligations under the City-payment option do not create an ERISA plan. Under the Ordinance, an employer has no responsibility other than to make the required payments for covered employees, and to retain records to show that it has

done so. The payments are made for a specific purpose, but the employer has no responsibility for ensuring that the payments are actually used for that purpose. The Association points to the burden entailed in keeping track of which workers perform qualifying work in San Francisco, keeping track of the hours those employees work, and keeping track of the credit (if any) an employer should get for health care payments made to non-City entities. This burden is not enough, in itself, to make payment obligation an ERISA plan. Many federal, state and local laws, such as income tax withholding, social security, and minimum wage laws, impose similar administrative obligations on employers; yet none of these obligations constitutes an ERISA plan.

We have emphasized that an employer's administrative duties must involve the application of more than a modicum of discretion in order for those administrative duties to amount to an ERISA plan. It is within the exercise of that discretion that an employer has the opportunity to engage in the mismanagement of funds and other abuses with which Congress was concerned when it enacted ERISA. In *Bogue v. Ampex Corp.*, 976 F.2d 1319, 1323 (9th Cir. 1992), we concluded that the employer, in determining whether an employee was eligible for severance pursuant to an employment agreement, "was obligated to apply enough ongoing, particularized, administrative, discretionary analysis to make the [severance] program in this case a 'plan.'" In *Velarde v. Pace Membership Warehouse, Inc.*, 105 F.3d 1313, 1317 (9th Cir. 1997), we emphasized that in order to amount to a "plan," the agreement must require the employer to apply more than "some modicum of discretion." There must be "*enough* ongoing, particularized, administrative, discretionary analysis to make

the plan an ongoing administrative scheme." *Id.* (emphasis in original; citation and internal quotation marks omitted).

An employer's administrative obligations under the City-payment option do not run the risk of mismanagement of funds or other abuse. To be sure, employers must keep track of the number of hours their employees work and whether those hours are worked in San Francisco or elsewhere. Employers must also determine whether particular employees are "supervisorial" or "managerial," and thereby not covered employees. S.F. Admin. Code § 14.1(b)(2)(d). An employer may have some incentive to minimize the number of covered employees or the number of reported hours worked in San Francisco, but the employer has no discretion under the Ordinance to alter its books to reduce its quarterly spending obligation. Rather, the employer's administrative obligations involve mechanical record-keeping, and the employer's payments to the City "are typically fixed, due at known times, and do not depend on contingencies outside the employee's control." *Morash*, 490 U.S. at 115. Any potentially subjective judgments involved with making these calculations and maintaining these records amount to nothing more than the exercise of "a modicum of discretion."

The Association contends that the administrative burden on the covered employers, combined with the reasonable ascertainability of benefits to employees, creates an ERISA plan. The Association contends that the employer's obligation to make payments to the City satisfies the criteria for a plan set forth in *Donovan v. Dillingham*, 688 F.2d 1367, 1370-73 (11th Cir. 1982) (en banc). Quoting *Donovan*, the Association argues, "Plan creation requires only that 'a rea-

sonable person could ascertain the intended benefits, beneficiaries, source of financing, and procedures for receiving benefits.' *Donovan*, 688 F.2d at 1373." We have relied on these criteria from *Donovan* in three primary circumstances in this circuit: in *Scott v. Gulf Oil Corp.*, 754 F.2d 1499 (9th Cir. 1985), in *Modzelewski v. Resolution Trust Corp.*, 14 F.3d 1374 (9th Cir. 1994), and in *Winterrowd v. American General Annuity Ins. Co.*, 321 F.3d 933 (9th Cir. 2003).

In *Scott*, we relied on the criteria set forth in *Donovan* to hold that an agreement to provide severance pay to terminated employees at a rate of two weeks' salary for each year of employment was sufficient to establish an ERISA plan. 754 F.2d at 1503-04. The outcome of *Scott* is almost certainly no longer good law in light of the Supreme Court's subsequent decisions in *Fort Halifax* and *Morash*.

In *Modzelewski*, we set forth the *Donovan* factors in determining whether an employer's promise to pay its employees monthly installments upon retirement amounted to a de facto pension plan. 14 F.3d at 1376. We concluded that "Because ERISA's definition of a pension plan is so broad, virtually any contract that provides for some type of deferred compensation will also establish a de facto pension plan." 14 F.3d at 1377. Because ERISA's definition of "employee pension benefit plan" is distinct from its definition of "employee welfare benefit plan," *Modzelewski* is not relevant to our analysis here. *See* 29 U.S.C. § 1002(1), (2)(A); *see also Carver v. Westinghouse Hanford Co.*, 951 F.2d 1083, 1086 (9th Cir. 1991).

In *Winterrowd*, we held that an accepted offer to provide termination benefits was not sufficiently specific in describing benefits to satisfy the *Donovan* cri-

teria, and that the offer therefore did not constitute an ERISA plan. 321 F.3d at 939. We did not hold in *Winterrowd* that an agreement satisfying the *Donovan* criteria, without more, constituted an ERISA plan. Rather, we held that an agreement not satisfying the *Donovan* criteria did not constitute an ERISA plan. In other words, satisfying the *Donovan* criteria was a necessary but not sufficient condition for the creation of an ERISA plan. *See Curtis v. Nev. Bonding Coip.*, 53 F.3d 1023, 1028 (9th Cir. 1995) (concluding that the *Donovan* criteria were not satisfied, and noting that "our court has not yet determined the minimum requirements for establishing the existence of an ERISA plan"); *see also Cinelli v. Sec. Pac. Corp.*, 61 F.3d 1437, 1442-44 (9th Cir. 1995) (concluding that because the *Donovan* criteria were not present there was no de facto employee welfare benefit plan).

The Association has not cited, and we have not discovered, any cases in which this court has applied the *Donovan* criteria to an employer's administrative obligations imposed by a state or local law. All of the cases applying the *Donovan* criteria address the question whether an informal, or de facto, ERISA plan has been established, and all involve some type of unwritten or informal promise made by an employer to its employees. We would be very hesitant to hold that the *Donovan* criteria apply to statutory administrative burdens imposed on an employer where, as here, that employer has made no promises whatsoever to its employees, which is what the Association urges us to do. We share the view expressed by the Seventh Circuit in *Sandstrom v. Cultor Food Science, Inc.*, 214 F.3d 795 (7th Cir. 2000):

> It is not clear that the approach taken in *[Donovan]* is compatible with more recent decisions of the Supreme Court, which emphasize different considerations when asking whether an informal policy or arrangement is a "plan." Both *Morash* and *Ft. Halifax* evince reluctance to find that regular and predictable awards of severance or vacation payments establish a "plan," given the frequency with which these benefits are the subject of bilateral negotiations between employers and departing employees.

Id. at 797 (citations omitted).

But we need not reach the question whether *Donovan* applies, for, in any event, its criteria are not satisfied. For employers who choose to make payments to the City, their obligation ceases as soon as they make the required payments. If an employer has made such payments to the City under the Ordinance, covered employees may enroll in the HAP free of charge or at a discounted rate. But as we will explain in more detail in a moment, there is nothing in the Ordinance that guarantees that a certain level or kind of "intended benefits" will be provided by the HAP, or that a particular group of "intended . . . beneficiaries" will be included in the HAP.

b. The HAP as an ERISA Plan

The Association expressly stated in its complaint that it "wholeheartedly supports the San Francisco Health Access Program and its laudable goals." It requested that the district court "issue declaratory and injunctive relief *without* disturbing all other lawful parts of the Ordinance unrelated to" the employer spending requirement. (Emphasis in original.) The Secretary of Labor, as *amicus curiae*, argues that the

HAP itself is an ERISA plan. If the Secretary is right, ERISA preempts not merely the employer spending requirements, but the HAP itself. We need not consider arguments raised solely by an *amicus*, particularly when they were not raised before the district court and when they are in tension with the strategic positions taken by the litigants. *See Russian River Watershed Prot. Comm. v. City of Santa Rosa*, 142 F.3d 1136, 1141 n.1 (9th Cir. 1998). Further, we need not consider arguments raised for the first time on appeal. *Choe v. Torres*, 525 F.3d 733, 740 n.9 (9th Cir. 2008). We address the Secretary's argument to indicate our disagreement with it, but we do not concede the correctness of the Secretary's implicit assumption that the argument is properly before us.

As described in greater detail above, the first element of an employee welfare benefit plan is the existence of a "plan, fund or program." *Patelco Credit Union*, 262 F.3d at 907. The HAP, administered by the City, is not an ERISA plan. Rather, the HAP is a government entitlement program available to low- and moderate-income residents of San Francisco, regardless of employment status.[4] It is funded pri-

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[4] The Secretary also argues that the HAP operates as "a government-run program for private employers," and therefore it is not entitled to the exemption under 29 U.S.C. § 1003(b)(1) from ERISA regulations. The ERISA exemption to which the Secretary refers applies when a government establishes and maintains an employee welfare benefit plan for its own employees. *See id.*; *see also* 29 U.S.C. § 1002(32). As the Secretary correctly notes, a government plan of that type loses its exemption when it opens up its plan to employees of private employers. The Secretary's argument is that the City has opened its exempt plan for its own employees to private employees and has thus forfeited its exemption. The Secretary's argument is without

marily by taxpayer dollars. Employer payments under the Ordinance provide only a small portion of the HAP's funding, and, although we do not know the precise numbers, employees covered under the Ordinance comprise substantially less than half of all HAP enrollees. The fact that a minority of HAP enrollees pay a discounted enrollment fee because their employers participate in the City-payment option is not enough to make the HAP a "plan, fund or program" within the meaning of ERISA. *See Waks v. Empire Blue Cross/Blue Shield*, 263 F.3d 872, 875 (9th Cir. 2001) (concluding that a converted individual policy was not itself an ERISA plan because the policy "covered [the plaintiff] as an individual and not as an employee of . . . any . . . employer").

The second element of an employee welfare benefit plan requires that the plan be "established or maintained by an employer through the purchase of insurance or otherwise." *Patelco Credit Union*, 262 F.3d at 907. An employer electing the City-payment option does not "establish[ ] or maintain[ ]" the HAP through its payments. The HAP exists, and will continue to exist, whether or not any covered employer makes a payment to the City under the Ordinance. Further, the employer has no control over whether its employees are eligible for the HAP. Under the terms of the ordinance, HAP eligibility is based on income level, age, uninsured status, and City residence, but the City is free to change the conditions of eligibility for HAP enrollment as it sees fit simply by amending

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foundation. The City does maintain an exempt employee welfare benefit plan for its own employees. The HAP, however, is not that plan. The City has never argued that the HAP is exempt from ERISA as a government-run plan for the City's own employees.

the Ordinance. Finally, neither the employer nor the covered employee has any control over the kind and level of benefits provided by the HAP. The employer never negotiates or signs a contract with the City, and the employer has no control over the City's coverage decisions. When the City administers the HAP, it does not act as the employer's agent entrusted to fulfill the benefits promises the employer made to its employees. An employer can make no promises to its employees with regard to the HAP or its coverage. In short, the City, rather than the employer, establishes and maintains the HAP, and the City is free to change the kind and level of benefits as it sees fit.

2. "Relates to" Employers' ERISA Plans

The Association's and the Secretary of Labor's second argument is that, even if the City-payment option does not create an ERISA plan, the Ordinance is preempted because it "relates to" *employers'* ERISA plans. 29 U.S.C. § 1144(a).

1131 Section 514(a) of ERISA states that ERISA preempts "any and all State laws insofar as they . . . relate to any employee benefit plan" governed by ERISA. 29 U.S.C. § 1144(a). The Supreme Court has established a two-part inquiry to interpret § 514(a): "A law 'relate[s] to' a covered employee benefit plan for purposes of § 514(a) if it [1] has a connection with or [2] reference to such a plan." *Dillingham*, 519 U.S. at 324 (alterations in original) (some internal quotation marks omitted). We consider these two inquiries in turn.

a. "Connection with" a Plan

In *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S.

645, 655 (1995), the Court acknowledged the difficulty of interpreting § 514(a):

> If "relate to" were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course . . . But that, of course, would be to read Congress's words of limitation as mere sham, and to read the presumption against pre-emption out of the law whenever Congress speaks to the matter with generality.

Likewise, the Court recognized that the two-part inquiry it had adopted to interpret § 514(a) did not provide much additional guidance in cases hinging on a law's "connection with an employee benefit plan. "For the same reasons that infinite relations cannot be the measure of pre-emption, neither can infinite connections." *Id.* at 656.

We read *Travelers* as narrowing the Court's interpretation of the scope of § 514(a). The Court reasoned it had to "go beyond the unhelpful text and the frustrating difficulty of defining [§ 514(a)'s] key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Id.*; *see also Gerosa v. Savasta & Co.*, 329 F.3d 317, 327 (2d Cir. 2003) (discussing how, among the circuits, the *Travelers* decision "occasioned a significant change in preemption analysis, and required careful reconsideration of any preexisting precedent dependent on the expansive view of 'related to' that held sway before it"). In this light, we employ a "holistic analysis guided by congressional intent." *Dishman v. UNUM Life Ins. Co. of Am.*, 269 F.3d 974, 981 n.15 (9th Cir. 2001); *see e.g., Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2001).

As noted above, one "purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans." *Davila*, 542 U.S. at 208. The purpose of ERISA's preemption provision is to "ensure[ ] that the administrative practices of a benefit plan will be governed by only a single set of regulations." *Fort Halifax Packing Co.*, 482 U.S. at 11. In *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990), the Court explained that

> Section 514(a) was intended to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government. Otherwise, the inefficiencies created could work to the detriment of plan beneficiaries.

In furtherance of ERISA' s goal of ensuring that "plans and plan sponsors [are] subject to a uniform body of benefits laws," the Court in *Egelhoff v. Egelhoff*, 532 U.S. 141 (2001), struck down a Washington State law that directed a choice of beneficiary that conflicted with the choice provided in an ERISA plan. The Court held that a state or local law has an impermissible "connection with" ERISA plans where it "binds ERISA plan administrators to a particular choice of rules for determining beneficiary status[,] . . . rather than [allowing administrators to pay the benefits] to those identified in the plan documents." *Id.* at 147. Similarly, in *Shaw v. Delta Air Lines*, 463 U.S. 85, 97-100 (1983), the Court held that ERISA preempts state laws "which prohibit[ ] employers from structuring their employee benefit plans" in a particular manner or "which require[ ] employers to pay employees specific benefits."

Consistent with these later-decided cases, in *Standard Oil Co. v. Agsalud*, 633 F.2d 760, 763 (9th Cir. 1980), *aff'd mem.*, 454 U.S. 801 (1981), we struck down a Hawaii statute that "require[d] employers in that state to provide their employees with a comprehensive prepaid health care plan." As the district court noted, the statute required that plan benefits include "a combination of features," and specifically "require[d] that the plans cover diagnosis and treatment of alcohol and drug abuse." *Standard Oil Co. v. Agsalud*, 442 F.Supp. 695, 696, 704 (N.D. Cal. 1977). The statute also imposed "certain reporting requirements which differ[ed] from those of ERISA." *Id.* at 696. In affirming the district court's opinion holding the Hawaii statute preempted under ERISA, we emphasized that the statute "directly and expressly regulate[d] employers and the *type of benefits they provide* employees," and that it therefore "related to" ERISA plans under § 514(a). *Agsalud*, 633 F.2d at 766 (emphasis added). That is, the Hawaii statute was preempted because it required employers to have health plans, and it dictated the specific benefits employers were to provide through those plans. *Id.* The statute thereby impeded ERISA's goal of ensuring that "plans and plan sponsors would be subject to a uniform body of benefits law." *Ingersoll-Rand Co.*, 498 U.S. at 142.

The Ordinance in this case stands in stark contrast to the laws struck down in *Egelhoff*, *Shaw* and *Agsalud*. The Ordinance does not require any employer to adopt an ERISA plan or other health plan. Nor does it require any employer to provide specific benefits through an existing ERISA plan or other health plan. Any employer covered by the Ordinance may fully discharge its expenditure obligations by making the required level of employee

health care expenditures, whether those expenditures are made in whole or in part to an ERISA plan, or in whole or in part to the City. The Ordinance thus preserves ERISA's "uniform regulatory regime." *See Davila*, 542 U.S. at 208. The Ordinance also has no effect on "the administrative practices of a benefit plan," *Fort Halifax Packing Co.*, 482 U.S. at 11, unless an employer voluntarily elects to change those practices.

A covered employer may choose to adopt or to change an ERISA plan in lieu of making the required health care expenditures to the City. An employer may be influenced by the Ordinance to do so because, when faced with an unavoidable obligation to make a payment at a certain level, it may prefer to make that payment to an ERISA plan. However, as *Travelers* makes clear, such influence is entirely permissible.

In *Travelers*, a New York statute required hospitals to collect surcharges from patients covered by commercial insurance companies, including those administering ERISA plans, but not from patients covered by Blue Cross/Blue Shield plans. The difference in treatment was justified on the ground that "the Blues pay the hospitals promptly and efficiently and, more importantly, provide coverage for many subscribers whom the commercial insurers would reject as unacceptable risks." *Travelers*, 514 U.S. at 658. The Court recognized that the surcharge might influence "choices made by insurance buyers, including ERISA plans." *Id.* at 659. But such an influence was not fatal to the New York statute: "An indirect economic influence . . . does not bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself[.] . . . Nor does the indi-

rect influence of the surcharges preclude uniform administrative practice[.]" *Id.* at 659-60.

In this case, the influence exerted by the Ordinance is even less direct than the influence in *Travelers*. In *Travelers*, the required surcharge on benefits provided under ERISA plans administered by commercial insurers inescapably changed the cost structure for those plans' health care benefits and thereby exerted economic pressure on the manner in which the plans would be administered. Here, by contrast, the Ordinance does not regulate benefits or charges for benefits provided by ERISA plans. Its only influence is on the employer who, because of the Ordinance, may choose to make its required health care expenditures to an ERISA plan rather than to the City.

Further, the Ordinance does not "bind[ERISA plan administrators to a particular choice of rules" for determining plan eligibility or entitlement to particular benefits. *See Egelhoff*, 532 U.S. at 147. Employers may "structur[e] their employee benefit plans" in a variety of ways and need not "pay employees specific benefits." *See Shaw*, 463 U.S. at 97. The Ordinance affects employers, but it "leave[s] plan administrators right where they would be in any case." *Travelers Ins. Co.*, 514 U.S. at 662. *See also WSB Elec., Inc. v. Curry*, 88 F.3d 788, 793 (9th Cir. 1996) ("The scheme does not force employers to provide any particular employee benefits or plans, to alter their existing plans, or to even provide ERISA plans or employee benefits at all."); *Keystone Chapter, Associated Builders & Contractors, Inc. v. Foley*, 37 F.3d 945, 960 (3d Cir. 1994) ("Where a legal requirement may be easily satisfied through means unconnected to ERISA plans, and only relates to ERISA plans at the election of an employer, it affects

employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan.") (some internal quotation marks omitted).

Finally, the Ordinance does not impose on plan administrators any "administrative [or] financial burden of complying with conflicting directives" relating to benefits law. *Ingersoll-Rand Co.*, 498 U.S. at 142. The Ordinance does impose an administrative burden on covered employers, for they must keep track of their obligations to make expenditures on behalf of covered employees and must maintain records to show that they have complied with the Ordinance. But these burdens exist whether or not a covered employer has an ERISA plan. Thus, they are burdens on the employer rather than on an ERISA plan. *See WSB Elec., Inc.*, 88 F.3d at 795 (rejecting the argument that a law "is preempted because it imposes additional administrative burdens regarding benefits contributions on *the employer*," where it did "not impose any additional burden on ERISA plans or require the employer to take any action with regard to those plans") (emphasis in original).

b. "Reference to" a Plan

To determine whether a law has a forbidden "reference to" ERISA plans, we ask whether (1) the law "acts immediately and exclusively upon ERISA plans," or (2) "the existence of ERISA plans is essential to the law's operation." *Dillingham*, 519 U.S. at 325.

Mackey v. Lanier Collection Agency & Service, Inc., 486 U.S. 825 (1988), demonstrates that the Ordinance is not preempted under the first part of the inquiry. In *Mackey*, the Court held that ERISA

preempted a provision of a state garnishment statute that specifically exempted ERISA benefits from the operation of the statute, even while the statute subjected other assets to garnishment. *Id.* at 828-29. The Court noted that the provision "solely applie[d] to" ERISA plans, and "single[d] out ERISA . . . plans for different treatment under state" law. *Id.* at 829-30. At the same time, however, the Court upheld those aspects of the state statute that did "not single out or specially mention ERISA plans of any kind," even though they would potentially subject ERISA plans to "substantial administrative burdens and costs." *Id.* at 831. In *Dillingham*, the Court characterized the preempted statute in *Mackey* as "act[ing] immediately and exclusively upon ERISA plans." *Dillingham*, 519 U.S. at 325. Here, unlike the preempted statute in *Mackey*, the Ordinance does not act on ERISA plans at all, let alone immediately and exclusively.

Two cases demonstrate that the Ordinance is not preempted under the second part of the inquiry. The first is *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 140 (1990), in which the Court held that ERISA preempted a state law that "ma[de] specific reference to, and indeed [wa]s premised on, the existence of an ERISA plan. In order for a party to bring a claim under the challenged law, "a plaintiff must plead, and the court must find, that an ERISA plan exists." *Id.* Here, by contrast, the Ordinance can have its full force and effect even if no employer in the City has an ERISA plan. Covered employers without ERISA plans can discharge their obligation under the Ordinance simply by making their required health care expenditures to the City.

The second case is *District of Columbia v. Greater Washington Board of Trade ("Greater Washington")*, 506 U.S. 125 (1992). A local ordinance required employers to provide workers' compensation benefits "measured by reference to 'the existing health insurance coverage' provided by the employer," and required that the coverage 'be at the same benefit level' as the existing coverage. *Id.* at 130. The Court held that the ordinance contained an impermissible "reference to" an ERISA plan because its requirement was measured by reference to the level of benefits provided by the employer's ERISA plan.

The district court in this case relied on the Court's opinion in *Greater Washington* in holding that the Ordinance is preempted. The district court wrote, "By mandating employee health benefit structures and administration, [the Ordinance's health care expenditure] requirements interfere with preserving employer autonomy over whether and how to provide employee health coverage, and ensuring uniform national regulation of such coverage." *Golden Gate Rest. Ass'n*, 535 F.Supp. 2d at 975. Further, according to the district court, "The provisions [of the Ordinance] require private employers to meet a certain level of benefits; and those benefits are the type regularly provided by employer ERISA plans." *Id.* at 976. The district court concluded, "This Court finds that [the structure of the Ordinance] is akin to the statute the Supreme Court found preempted in *District of Columbia v. Greater Washington Board of Trade* which required the employer to provide the same amount of health care coverage for workers eligible for workers compensation." *Id.* at 978.

There is a critical distinction between the ordinance in *Greater Washington* and the Ordinance in

this case. Under the ordinance in *Greater Washington*, obligations were measured by reference to the level of *benefits* provided by the ERISA plan to the employee. Under the Ordinance in our case, by contrast, an employer's obligations to the City are measured by reference to the *payments* provided by the employer to an ERISA plan or to another entity specified in the Ordinance, including the City. The employer calculates its required payments based on the hours worked by its employees, rather than on the value or nature of the benefits available to ERISA plan participants. Thus, unlike the ordinance in *Greater Washington*, the Ordinance in this case is not determined, in the words of § 514(a), by "reference to" an ERISA plan.

The Ordinance in this case is conceptually similar to a California prevailing wage statute challenged in *WSB Electric, Inc. v. Curry*, 88 F.3d 788 (9th Cir. 1996). In that case, the California statute required an employer to pay the prevailing wage, consisting of a combination of cash and benefits. To calculate the total wage, the employer added the hourly cash wage to its hourly contribution to the employee's benefit package. However, the statute required that a certain minimum amount be paid as a cash wage, a requirement which had the effect of putting a cap on the amount the employer could be credited for payments made to fund a benefit package. The employer was free to contribute more than the cap amount to a benefit package, but any amount above the cap was not counted toward satisfaction of the prevailing wage requirement. *Id.* at 790-91.

The plaintiffs in *WSB Electric* contended that the California statute was preempted by ERISA, pointing out that some of the employers were making payments

to ERISA plans, and that benefits were paid out to the employees under these plans. *Id.* at 792-93. We held, however, that the statute was not preempted. We wrote:

> At most, this scheme provides examples of the types of employer contributions to benefits that are included in the wage calculation. The scheme does not force employers to provide any particular employee benefits or plans, to alter their existing plans, or to even provide ERISA plans or employee benefits at all. These provisions are enforced regardless of whether the individual employer provides benefits through ERISA plans, or whether the benefit contributions in a given locality are paid to ERISA plans.

Id. at 793-94 (citation and footnote omitted). Here, as in *WSB Electric*, employers need not have any ERISA plan at all; and if they do have such a plan, they need not make any changes to it. Where a law is fully functional even in the absence of a single ERISA plan, as it was in *WSB Electric* and as it is in this case, it does not make an impermissible reference to ERISA plans. *Cf. Travelers Ins. Co.*, 514 U.S. at 656 ("The surcharges are imposed upon patients and HMO's, regardless of whether the commercial coverage or membership, respectively, is ultimately secured by an ERISA plan, private purchase, or otherwise, with the consequence that the surcharge statutes cannot be said to make 'reference to' ERISA plans in any manner.").

C. *Retail Industry Leaders Association v. Fielder*

Finally, the Association contends that the Ordinance is preempted under the analysis set forth in *Retail Industry Leaders Association v. Fielder*, 475

F.3d 180, 183 (4th Cir. 2007). The Association contends that we will create a circuit split if we uphold the Ordinance. We disagree. We see no inconsistency between the Fourth Circuit's holding in *Fielder* and our holding in this case.

We neither adopt nor reject the analysis of the Fourth Circuit in *Fielder*. The panel majority in that case held a Maryland law preempted over a forceful dissent. *Id.* at 201-04 (Michael, J., dissenting); *see also* Catherine L. Fisk & Michael M. Oswalt, *Preemption and Civic Democracy in the Battle over Wal-Mart*, 92 Minn. L. Rev. 1502, 1514-20 (2008). For purposes of argument, however, we assume that the panel majority in *Fielder* was correct. But even under the reasoning of the panel majority, San Francisco's Ordinance is valid.

The Maryland law at issue in *Fielder* required "employers with 10,000 or more Maryland employees to spend at least 8% of their total payrolls on employees' health insurance costs or pay the amount their spending falls short to the State of Maryland." *Fielder*, 475 F.3d at 183 (majority opinion). The Maryland law gave nothing in return—either to an employer or its employees—for the employer's payment to the State.

Wal-Mart was the only employer in Maryland affected by the law's minimum spending requirements. On the face of the law, Wal-Mart appeared to have two options. To reach the required spending level of 8%, it could either increase contributions to its own ERISA plan, or it could pay money to the State of Maryland. But the Fourth Circuit concluded that, in practical fact, Wal-Mart had no choice. The court wrote that Wal-Mart had "noted by way of affidavit [that] it would not pay the State a sum of

money that it could instead spend on its employees' healthcare." *Id.* at 193. The Fourth Circuit wrote in *Fielder*:

> This would be the decision of any reasonable employer. Healthcare benefits are a part of the total package of employee compensation an employer gives in consideration for an employee's services. An employer would gain from increasing the compensation it offers employees through improved retention and performance of present employees and the ability to attract more and better new employees. In contrast, an employer would gain nothing in consideration of paying a greater sum of money to the State. Indeed, it might suffer from lower employee morale and increased public condemnation.
>
> In effect, the only rational choice employers have under the [Maryland law] is to structure their ERISA healthcare benefit plans so as to meet the minimum spending threshold.

Id. The court wrote further: "[T]he amount that the [Maryland law] prescribes for payment to the State is actually a fee or a penalty that gives the employer an irresistible incentive to provide its employees with a greater level of health benefits." *Id.* at 194. Therefore, the court concluded, "the choices given in the [Maryland law] . . . are not meaningful alternatives by which an employer can increase its healthcare spending to comply with the [law] without affecting its ERISA plans." *Id.* at 196.

In stark contrast to the Maryland law in *Fielder*, the City-payment option under the San Francisco Ordinance offers employers a meaningful alternative that allows them to preserve the existing structure of

their ERISA plans. If an employer elects to pay the City, that employer's employees are eligible for free or discounted enrollment in the HAP, or for medical reimbursement accounts. In contrast to the Maryland law, the San Francisco Ordinance provides tangible benefits to employees when their employers choose to pay the City rather than to establish or alter ERISA plans. In its motion for summary judgment, the Association provided no evidence to demonstrate that San Francisco employers are, in practical fact, compelled to alter or establish ERISA plans rather than to make payments to the City.[5]

Because the City-payment option offers San Francisco employers a realistic alternative to creating or altering ERISA plans, the Ordinance does not "effectively mandate[ ] that employers structure their employee healthcare plans to provide a certain level of benefits." *See Fielder*, 475 F.3d at 193. In the view of the *Fielder* court, Maryland legislators intended to "force Wal-Mart to increase its spending on healthcare benefits rather than to pay monies to the State." *Id.* at 185. Unlike the Maryland law, the San Francisco Ordinance provides employers with a legitimate alternative to establishing or altering ERISA plans. *See Travelers Ins. Co.*, 514 U.S. at 664 (stating that if

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[5] We do not rely on the following to support our decision, but we note that San Francisco has reported that as of May 1, 2008, more than seven hundred San Francisco employers have elected to comply with the Ordinance by making their health care expenditures directly to the City. Office of the Mayor, City & County of S.F., Mayor Newsom Announces Hundreds of Employers Signing Up for Healthy San Francisco Program, May 1, 2008, http://www.healthysanfrancisco.org/files/PDF/HSF Release 5.1.2008.pdf. This document indicates that 734 employers had elected to make payments to the City on behalf of 12,900 employees. *Id.*

the New York surcharges had been "an exorbitant tax," they might leave ERISA plan purchasers "with a Hobson's choice," thereby amounting to an impermissible substantive mandate, but concluding that there was no evidence that the surcharges are so prohibitive as to force all health insurance consumers to contract with the Blues"). We therefore conclude that the San Francisco Ordinance does not compel covered employers to establish or to alter ERISA plans. *Cf. Fielder*, 475 F.3d at 193.

Conclusion

There may be better ways to provide health care than to require employers in the City of San Francisco to foot the bill. But our task is a narrow one, and it is beyond our province to evaluate the wisdom of the Ordinance now before us. We are asked only to decide whether § 514(a) of ERISA preempts the employer spending requirements of the Ordinance. We hold that it does not. The spending requirements do not establish an ERISA plan; nor do they have an impermissible connection with employers' ERISA plans, or make an impermissible reference to such plans.

We therefore REVERSE the judgment of the district court and REMAND with instructions to enter summary judgment in favor of the City and Intervenors.

APPENDIX B

FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 07-17370
D.C. No. CV-06-06997-JSW

GOLDEN GATE RESTAURANT, ASSOCIATION,
an incorporated non-profit trade association,
Plaintiff-Appellee,

v.

CITY AND COUNTY OF SAN FRANCISCO,
Defendant,

SAN FRANCISCO CENTRAL LABOR COUNCIL; SERVICE EMPLOYEES INTERNATIONAL UNION, HEALTHCARE WORKERS-WEST; SERVICE EMPLOYEES INTERNATIONAL UNION, LOCAL 1021; UNITE HERE LOCAL 2,
Defendant-intervenors-Appellants.

No. 07-17370
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GOLDEN GATE RESTAURANT, ASSOCIATION, an incorporated non-profit trade association,
Plaintiff-Appellee,

v.

CITY AND COUNTY OF SAN FRANCISCO,
Defendant,

SAN FRANCISCO CENTRAL LABOR COUNCIL; SERVICE EMPLOYEES INTERNATIONAL UNION, HEALTHCARE WORKERS-WEST; SERVICE EMPLOYEES INTERNATIONAL UNION, LOCAL 1021; UNITE HERE LOCAL 2,
Defendant-intervenors-Appellants.

Filed March 9, 2009

ORDER DENYING PETITION FOR REHEARING EN BANC

ORDER

Before: Alfred T. Goodwin, Stephen Reinhardt, and William A. Fletcher, Circuit Judges.

Order; Concurrence by Judge W. Fletcher; Dissent by Judge Milan D. Smith, Jr.

Judge Reinhardt and Judge Fletcher voted to deny the petition for rehearing en banc, and Judge Goodwin so recommended.

A judge of the court called for a vote on the petition for rehearing en banc. A vote was taken, and a majority of the active judges of the court failed to vote for en banc rehearing. Fed. R. App. P. 35(f). Judge Berzon was recused.

The petition for rehearing en banc, filed October 22, 2008, is DENIED.

W. FLETCHER, Circuit Judge, concurring in the denial of rehearing en banc:

A majority of the active judges of our court declined to vote for rehearing of this case en banc. I concur in the court's decision not to go en banc. I write to respond to the dissent from that decision.

The question is whether the San Francisco Health Care Security Ordinance ("the Ordinance") is pre-empted by ERISA. We describe the Ordinance in detail in our opinion. *See Golden Gate Restaurant Ass 'n v. City and County of San Francisco*, 546 F.3d 639, 643-47 (9th Cir. 2008). In brief, the Ordinance requires San Francisco employers to pay to the City of San Francisco what amounts to a tax. The tax is either $1.17 or $1.76 per hour per employee, depending on the profit or non-profit status of the employer and the number of employees. No employer is required by the Ordinance either to establish a new ERISA health care plan or to modify an existing ERISA health care plan. An employer may fully satisfy its obligation under the Ordinance by paying the tax to the City.

The Ordinance requires that San Francisco use the employers' payments to help support a City-administered program that provides health care to low- and moderate-income residents of San Francisco. The program is called the Health Access Program ("the HAP"). The employers' payments comprise only part of the support for the HAP. Some of those receiving health care under the HAP are employees of covered employers, but most are not. The Ordinance gives a covered employer a dollar-for-dollar credit for any amount paid by that employer for health care for its employees. That credited amount may be—but need not be—paid to an ERISA health care plan. The only

requirement in order to receive the credit is that the payment be for some form of health care. The benefits obtained by an employer's health care payments (as distinct from the amount paid for those benefits) are irrelevant to the calculation of the credit given to the employer.

The dissent makes several contentions. I disagree with all of them.

First, the dissent contends that our decision creates a circuit conflict with *Retail Industry Leaders Ass'n v. Fielder*, 475 F.3d 180 (4th Cir. 2007). At issue in *Fielder* was ERISA preemption of a Maryland law that required "employers with 10,000 or more Maryland employees to spend at least 8% of their total payrolls on employees' health insurance costs or pay the amount their spending falls short to the State of Maryland." *Id.* at 183. The only employer covered by the Maryland law was Wal-Mart. The Maryland law gave nothing in return—either to the Wal-Mart or its employees—for Wal-Mart's payment to the State.

Despite what appeared on the face of the Maryland law to be a choice between increasing ERISA health care coverage and paying money to the State, the Fourth Circuit held that the law impermissibly "related to" an ERISA plan. In the view of the court, there was no real choice. Instead, the inevitable effect of the law was to require Wal-Mart to increase its ERISA coverage of its employees. The court wrote:

> This would be the decision of any reasonable employer. Healthcare benefits are a part of the total package of employee compensation an employer gives in consideration for an employee's services. An employer would gain from increas-

> ing the compensation it offers employees through improved retention and performance of present employees and the ability to attract more and better new employees. In contrast, an employer would gain nothing in consideration of paying a greater sum of money to the State. Indeed, it might suffer from lower employee morale and increased public condemnation.
>
> *In effect, the only rational choice employers have under the [Maryland law] is to structure their ERISA healthcare benefit plans so as to meet the minimum spending threshold.*

Id. at 193 (emphasis added).

The Maryland law contrasts sharply with the San Francisco Ordinance. Under the Ordinance, an employer gains an advantage from its payments to the City, because employees of covered employers are entitled to obtain health care benefits from the HAP at reduced rates. Far from imposing a de facto obligation on an employer to establish or alter an ERISA plan, the Ordinance offers an employer a meaningful choice. As of May 1, 2008, more than seven hundred San Francisco employers had elected to pay money to the City rather than to alter their other health care expenditures. *Golden Gate*, 546 F.3d at 660 n.5.

The dissent nonetheless contends that our decision conflicts with *Fielder*. It contends, "Covered employers under San Francisco's Ordinance must coordinate their non-ERISA payments with their ERISA plans in the very manner the *Fielder* court deemed impermissible." Dissent at 2828. In support, the dissent quotes the first and last sentences from a passage

from *Fielder* but omits the intervening three sentences. The full passage is as follows:

> If Wal-Mart were to attempt to utilize non-ERISA health spending options to satisfy the [Maryland law], it would need to coordinate those spending efforts with its existing ERISA plans. For example, an individual would be eligible to establish a Health Savings Account only if he is enrolled in a high deductible health plan. In order for Wal-Mart to make widespread contributions to Health Savings Accounts, *it would have to alter its package of ERISA health insurance plans* to encourage its employees to enroll in one of its high deductible health plans. From the employer's perspective, the categories of ERISA and non-ERISA healthcare spending would not be isolated, unrelated costs. Decisions regarding one would affect the other and thereby violate ERISA's preemption provision.

Fielder, 475 F.3d at 196-97 (emphasis added) (citation omitted).

The omitted sentences make clear the difference between the Maryland law and the San Francisco Ordinance. If Wal-Mart chose to use non-ERISA spending options under the Maryland law, "it would have to alter its package of ERISA health insurance plans." *Id.* That is, Wal-Mart's use of the non-ERISA spending option would necessarily produce a change in its ERISA plans. This is not true under the San Francisco Ordinance. An employer's payment of the de facto tax to the City does not produce any change in any ERISA plan.

Second, the dissent contends that our decision conflicts with two Supreme Court decisions, *Egelhoff*

v. Egelhoff, 532 U.S. 141 (2001), and *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125 (1992).

In *Egelhoff* the challenged state statute required ERISA plan administrators to follow state law in designating plan beneficiaries. The Court held the statute preempted because it "binds ERISA plan administrators to a particular choice of rules for determining beneficiary status." *Egelhoff*, 532 U.S. at 147. The Court wrote, "Plan administrators must either follow [the State's] beneficiary designation scheme or alter the terms of their plan so as to indicate that they will not follow it." *Id.* at 150. Because the statute in *Egelhoff* required a change in an ERISA plan under either choice, it was preempted. By contrast, the San Francisco Ordinance does not require any change to any ERISA plan.

In *Greater Washington*, a Washington, D.C. ordinance required employers to provide workers' compensation benefits to their employees. The level of required benefits was "measured by reference to the existing health insurance coverage provided by the employer." *Greater Washington*, 506 U.S. at 130. The Court held that the requirement that benefits be determined by reference to benefits provided in ERISA plans was an impermissible reference to an ERISA plan. By contrast, the San Francisco Ordinance requires employers to provide money to the City (rather than benefits to the employee), and determines the level of required payment by reference to hours worked by an employee (rather than by reference to benefits provided under an ERISA plan). An employer's required payment to the City may be reduced or eliminated if the employer makes payments to an employee's ERISA plan or to another

healthcare-providing entity; but the amount of the reduction is determined by reference to the amount of money paid.

Finally, the dissent contends that ERISA responds to the "need for nationally uniform plan administration" and a "uniform regulatory system." Dissent at 2832. The purpose of ERISA is not to require national uniformity in the provision of health care. Rather, its purpose is to "ensure[ ] that the administrative practices of a benefit plan will be governed by only a single set of regulations." *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987). Nothing in the Ordinance requires the employer to establish an ERISA plan or to alter an existing ERISA plan, and nothing in the Ordinance interferes in any way with the uniformity of ERISA regulations.

M. SMITH, Circuit Judge, with whom KOZINSKI, Chief Judge, and O'SCANNLAIN, KLEINFELD, TALLMAN, BYBEE, CALLAHAN, and BEA, Circuit Judges, join dissenting from the denial of rehearing en banc:

I respectfully dissent from our court's denial of rehearing this case en banc. Our decision in this case creates a circuit split with the Fourth Circuit Court of Appeals, renders meaningless the tests the Supreme Court set out in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983), conflicts with other Supreme Court cases establishing ERISA[1] preemption guidelines, and, most importantly, flouts the mandate of national uniformity in the area of employer-provided healthcare that underlies the enactment of ERISA. Our decision allows San Francisco to create an ordinance that effectively requires "ERISA administrators to master the relevant laws of 50 States"—which in turn "undermine[s] the congressional goal of 'minimiz[ing] the administrative and financial burden[s]' on plan administrators—burdens ultimately born by the beneficiaries." *Egelhoff v. Egelhoff*, 532 U.S. 141, 149-50 (2001).

The panel opinion creates "'a road map for state and local governments'"[2] seeking to regulate employee health plans despite ERISA's preemptive mandate. In my view, if our decision in this case remains good law, similar laws will become commonplace, and the congressional goal of national uniformity in the area of employer-provided healthcare will

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[1] Employee Retirement Income Security Act of 1974 (ERISA).

[2] Jason Dearen, Federal Court Upholds San Francisco Healthcare Program, L.A. Times, Sept. 30, 2008 (quoting City Attorney Dennis Herrera).

be thoroughly undermined, with significant adverse consequences to employers and employees alike.

I

The San Francisco Health Care Security Ordinance (Ordinance, or San Francisco Ordinance) requires that covered employers[3] within San Francisco make minimum "expenditures" to their own programs for their employees' health care *or* instead make contributions in the required amounts to the city. These alternative contributions go to finance either San Francisco's Health Access Program (HAP) or health "reimbursement accounts." The HAP serves uninsured San Francisco residents, while the "reimbursement accounts" are assigned to employees of the covered employers. For large businesses, the required employer's rate in 2008 for health care expenditures is $1.76 for each hour worked by a covered employee. The Ordinance also imposes extensive record keeping and reporting requirements on San Francisco employers, and creates penalties for employers who fail to comply with these requirements.[4]

Golden Gate Restaurant Association (GGRA) filed suit on November 8, 2006 against the City of San Francisco, in the Northern District of California, asking the district court to find that ERISA preempts

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[3] A covered employer is a for-profit employer engaged in business in San Francisco for whom at least twenty persons work, or a nonprofit employer in San Francisco for whom at least fifty persons work. San Francisco Health Care Security Ordinance (HSAO), §§ 14.1(b)(3), 14.1(b)(4) and 14.1(b)(15).

[4] The Ordinance requires covered employers to keep "accurate records of health care expenditures, required health care expenditures, and proof of such expenditures made each quarter each year." HSAO § 14. l(b)(i).

the employer spending requirements of the Ordinance, and seeking a permanent injunction against enforcement of those provisions. The parties filed cross-motions for summary judgment.

On December 27, 2007, Judge Jeffrey S. White entered judgment for GGRA, finding that ERISA Section 514(a) preempts the Ordinance. *Golden Gate Rest. Ass'n v. City & County of San Fran.*, 535 F. Supp. 2d 968 (N.D. Cal. 2007). Section 514(a) states that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." To determine whether the Ordinance "related to" an employee benefit plan, Judge White applied the two tests articulated by the Supreme Court in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983). These tests examine (1) whether a law has a "connection with" employers' ERISA-regulated plans, or (2) whether such law makes "reference to" such employer-sponsored plans. If either test is met, the ordinance is preempted under Section 514(a). Judge White found the San Francisco Ordinance preempted under both tests. 535 F. Supp. 2d at 975.

Applying the first test, Judge White found that the Ordinance has an impermissible connection with affected employer ERISA plans in four ways: (1) "the Ordinance affects plan administration, a core area of ERISA concern"; (2) the enforcement provisions impermissibly "impose on employers specific record keeping, inspection and other administrative burdens" which are "ongoing and directly affect" the scheme of health care benefits; (3) "the Ordinance directly and indirectly affects the structure and administration of ERISA plans"; and (4) the Ordinance "has a prohibited connection with ERISA plans because it interferes with nationally uniform plan

administration." *Id.* at 975-77. Although the district court acknowledged that required payments under the Ordinance could be made directly to a public entitlement program, effectively bypassing employer ERISA plans, "[t]he undeniable fact is that the vast majority of any employer's healthcare spending occurs through ERISA plans. Thus, the primary subjects of the [expenditure requirements] are ERISA plans, and any attempt to comply with the statute would have direct effects on the employer's ERISA plans." *Id.* at 976 (quoting *Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180, 196 (4th Cir, 2007)).

Applying the second Shaw test, Judge White found that the Ordinance impermissibly makes reference to employers' ERISA plans by defining "health care expenditure" in such a way that compliance can only be determined with reference to the employer's ERISA-regulated health plan.[5] I believe Judge White's well reasoned opinion should have been upheld by our court.

II

Our merits panel disagreed with Judge White, and determined that the Ordinance does not "relate to" ERISA plans. The panel reasoned that because the Ordinance does not require an employer to adopt an ERISA plan or to provide benefits though an ERISA plan (as a covered employer can discharge its expenditure obligations by making payments to the city), the Ordinance sidesteps Section 514(a) preemption. The panel also indicated that the Ordinance was

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[5] Judge White did not, as the plaintiff and many of the amici urged, find that payments to the city under the Ordinance created an ERISA plan.

not preempted because it regulated employer payments instead of employee benefits.

A

In so holding, the panel's decision conflicts with a recent case from the Fourth Circuit Court of Appeals. In 2007, the Fourth Circuit struck down a similar state statute in *Fielder*, 475 F.3d at 183.[6] In that case, the ordinance at issue required covered employers to spend at least 8% of their payroll costs on health insurance, or else to pay a like sum of money to the state of Maryland. *Fielder* held that ERISA Section 514(a) preempted the Maryland statute because the statute forced employers either to make minimum health care contributions to ERISA plans for its employees or to make contributions to Maryland's Health Care Fund. The Fourth Circuit recognized that "categories of ERISA and non-ERISA healthcare spending [are not] isolated, unrelated costs." *Id.* at 197. Further, the court reasoned that "fair share laws," such as the Maryland law, were impermissibly connected with ERISA plans because they "would disrupt employers' uniform administration of employee benefit plans on a nationwide basis." *Id.* at 194.

In *Golden Gate*, the panel distinguishes *Fielder* by noting that the Maryland law created no "meaningful alternative" for the employer other than increasing their current health plans. The alternative, which the panel dismissed, was simply a tax on the employers, which was not earmarked towards their employees'

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[6] In addition, in *Retail Indus. Leaders Ass'n v. Suffolk County*, 497 F. Supp. 2d 403 (E.D.N.Y. 2007), the Eastern District of New York held that ERISA preempts a similar Suffolk County ordinance.

insurance, but rather towards general entitlement funds. Our panel implies that in the San Francisco Ordinance, the municipally funded health alternative is somehow more "meaningful." This meaning ostensibly comes from the fact that employers are still contributing to their specific employees health care, albeit through the administration of the city.

Such a distinction conflicts with the reasoning of *Fielder*. The *Fielder* court explained that even were there a more "meaningful avenue" by which the employer could make nonERISA healthcare payments, the Maryland statute was still impermissibly connected to ERISA plans. 475 F.3d at 196-97 ("If [the employer] were to attempt to utilize non-ERISA health spending options to [comply with the statute], it would need to coordinate those spending efforts with its existing ERISA plans. . . . Decisions regarding one would affect the other and thereby violate ERISA's preemption provision."). Covered employers under San Francisco's Ordinance must coordinate their non-ERISA payments with their ERISA plans in the very manner the *Fielder* court deemed impermissible. When determining how much, if any, payment they have to make to the city to be in compliance, they necessarily need to evaluate and coordinate with their existing ERISA plans. A currently non-complying employer in San Francisco has the same choice as a non-complying employer in Maryland: Make a payment to the government or change its current ERISA plan. Where the employer's payment goes after the employer makes its choice does not change the fundamental nature of the payment from a penalty to a "meaningful avenue."

The holdings of *Fielder* and *Golden Gate* stand in clear opposition, and create a circuit split on the issue

of whether ERISA preempts "fair share" or "play-or-pay" ordinances.

B

Further, the *Golden Gate* panel opinion disregards important case law setting forth ERISA preemption principles. ERISA preemption's "goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government . . . , [and to prevent] the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction." *NY. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656-57 (1995) (quoting *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990)). The burden of conflicting obligations on employers operating in multiple jurisdictions "is exactly the burden that ERISA seeks to eliminate." *Egelhoff*. 532 U.S. at 151. "Requiring ERISA administrators to master the relevant laws of 50 States . . . would undermine the congressional goal of 'minimiz[ing] the administrative and financial burden[s]' on plan administrators—burdens ultimately born by the beneficiaries." *Id.* at 149-50 (quoting *Ingersoll-Rand Co.*, 498 U.S. at 142). The opinion in *Golden Gate* conflicts with these ERISA preemption principles.

In *Egelhoff*, the Court dismissed the argument that states can avoid preemption by offering employers a theoretical means to avoid changing their current ERISA plans. 532 U.S. at 147-48. Although employers were able to "opt out of the state law requirement, the law had "a connection with" the ERISA plan and was thus preempted. *Id.* at 150. The court held that "[t]he statute is not any less of a regulation of the

terms of ERISA plans simply because there are two ways of complying with it." *Id.* The San Francisco Ordinance at issue here is similarly connected, as it structures employers' choices with respect to their existing ERISA plans. Noncomplying San Francisco employers have a choice: either increase or maintain their health care expenditures under their own plans, or, pay enough to the city to satisfy that mandated minimum. Per *Egelhoff* a law like the San Francisco ordinance is ERISA-preempted because it frames employers' choices in this fashion.

Further, allowing San Francisco to pose such a choice would strike at the heart of ERISA because the plan administrators would have to account for potential opt-out provisions in all 50 states. *Id.* at 151. *Egelhoff* explained this burden:

> It is not enough for plan administrators to opt out of this particular statute. Instead, they must maintain a familiarity with the laws of all 50 States so that they can update their plans as necessary to satisfy the opt-out requirements of other, similar statutes. They also must be attentive to changes in the interpretations of those statutes by state courts. This "tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction" is exactly the burden ERISA seeks to eliminate.

Id. (quoting *Indersoll-Rand*, 498 U.S. at 142). The Ordinance here places employers in a similar situation. As the Secretary of Labor observes, while the "administrative burden imposed by a single law may be tolerable, the cumulative burden could be staggering and runs directly counter to ERISA's goal of encouraging employers, who may operate nationally, voluntarily to provide uniform employee benefits

under the legal framework provided by a federal scheme with intentionally broad preemptive force." Secretary's Amicus Brief, at 15.

In addition, the *Golden Gate* opinion conflicts with *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125 (1992). In that case, a D.C. ordinance required employers to provide the same medical coverage to injured employees as to non-injured, active employees. The Supreme Court struck down the ordinance, explaining that the statute impermissibly referred to an ERISA plan. *Id.* at 130. This was so even though D.C. employers did not need to amend their ERISA plans to comply with the ordinance; they could provide benefits for injured employees through a separate or non-ERISA plan. The Court found that the statute was preempted, however, because the benefits had to be equal, thereby requiring a comparison to the ERISA plan. Similarly, in *Golden Gate*, although covered employers may not need to amend their ERISA plans under the Ordinance, they can only determine their compliance by using their current ERISA plans as a reference.

The *Golden Gate* opinion attempted to distinguish this case by claiming that a "critical distinction" existed because "[u]nder the ordinance in *Greater Washington*, obligations were measured by reference to the level of *benefits* provided by the ERISA plan to the employee. Under the Ordinance in our case . . . [obligations] are measured by reference to the *payments* provided by the employer to an ERISA plan or to another entity." 546 F.3d at 658. Thus, the panel implies that the D.C. statute would have survived had the statute required covered employers to spend the same amount for injured and non-injured em-

ployees instead of requiring the benefits be equal. This distinction has no basis in the text of *Greater Washington* and greatly revises ERISA preemption case law.

Finally, and most importantly, I dissent because this case concerns an issue of exceptional national importance, i.e., national uniformity in the area of employer-provided healthcare. The Fourth Circuit in *Fielder* and the district court here both considered the need for nationally uniform plan administration to be the central concern of the Supreme Court's ERISA preemption case law. The diverse interests of the amicus groups who wrote in support of both positions indicates the level of far-reaching national importance the *Golden Gate* decision has for many groups across the United States.[7]

At the time of ERISA's enactment, a coalition reflecting employer and labor interests sought the establishment of a uniform regulatory system for retirement and welfare benefit plans.[8] As amici the

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[7] The plaintiff-appellants had eight amicus briefs submitted in support of their position, by the United States Department of Labor, National Federation of Independent Business Legal Foundation, Retail Industry Leaders Association/ United States Chamber of Commerce, Human Resource Policy Association, Employers Group/California Chamber of Commerce, International Franchise Association/Society for Human Resource Management/National Association of Manufacturers, ERISA Industry Committee/National Business group on Health, and the American Benefits Council. The defendants-appellees had two amicus briefs submitted in support of their position, by the American Association of Retired People and the Attorney General of the State of California.

[8] Wooten, James A., "A Legislative and Political History of ERISA Preemption, Part 2." JOURNAL OF PENSION BENEFITS, Vol. 14, No. 3, p. 10, Spring 2007; Buffalo Legal Studies Re-

ERISA Industry Committee and the National Business Group on Health note in their brief, the legislators who helped push ERISA through Congress were focused on a broad preemption provision. Senator Javits remarked that "the emergence of a comprehensive and pervasive Federal interest and the interests of uniformity with respect to interstate plans required . . . the displacement of State action in the field of private employee benefits programs." 129 Cong. Rec. 29942 (Aug. 22, 1974). Representative Dent remarked, "[w]ith the preemption of the field, we round out the protection afforded to participants by eliminating the threat of conflicting and inconsistent State and local regulation." *Id.* Finally, Senator Williams added:

> [T]he substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans. This principle is intended to apply in the broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law.

Id. The *Golden Gate* panel opinion ignores ERISA's preemption goals and instead focuses on ERISA's objective of protecting against misuse of benefit plan funds. While misuse was undoubtedly a concern, it is clear from the cited language that preemption was central to ERISA's implementation.

The problems that the Ordinance poses to multi-jurisdictional employers are significant. Without un-

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search Paper No. 2007-018. Available at SSRN: http://ssrn.com/abstract=1023699.

iformity, multi-state employers cannot offer all of their similarly situated employees the same benefits, and creates no possibility of continuity in benefit programs. Our panel's decision essentially guarantees, for example, that employees of a national chain restaurant in Oakland will receive different benefits than similarly situated employees of the same restaurant just a few miles away in San Francisco. Uniformity is essential to ensuring that employees understand what benefits they are entitled to and how to obtain them. Covered employers in San Francisco must continuously monitor the City's spending targets, make quarterly calculations for health care expenditures, keep abreast of varying definitions for different employees, track eligibility waiting periods for each individual employee, and maintain the records keeping requirements of the Ordinance. While this may not be difficult on a small scale, if we consider the possibility of numerous cities, counties and states enacting similar laws, the burden this places on employers is potentially very great, thereby encouraging affected employers to drop their ERISA plans as a cost saving measure. If upheld, *Golden Gate* will undoubtedly serve as a roadmap in jurisdictions across the country on how to design and enact a labyrinth of laws requiring employer compliance on health care expenditures, thereby creating the very kind of health care expenditure balkanization ERISA was intended to avoid.

III

I dissent because I believe the San Francisco Ordinance is clearly preempted by ERISA Section 514(a). Contrary to the arguments made by Judge W. Fletcher in both the Concurrence and the original panel opinion, our decision here creates a circuit split

with the Fourth Circuit, undercuts the Supreme Court's ERISA preemption case law, and creates a roadmap for the enactment of numerous conflicting health care laws affecting national employers, the very situation Congress strove to avoid when it enacted ERISA.

APPENDIX C

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Nos. 07-17370, 07-17372

GOLDEN GATE RESTAURANT ASSOCIATION,
Plaintiff-Appellee,

v.

CITY AND COUNTY OF SAN FRANCISCO,
Defendants-Appellants

and

SAN FRANCISCO CENTRAL LABOR COUNCIL, SERVICE EMPLOYEES INTERNATIONAL UNION LOCAL 1021, SEIU UNITED HEALTHCARE WORKERS-WEST, and UNITE-HERE! LOCAL 2,
Intervenors-Appellants.

On Appeal from the United States District Court
for the Northern District of California

BRIEF FOR THE SECRETARY OF LABOR
AS AMICUS CURIAE SUPPORTING
PETITION FOR REHEARING

Decided September 30, 2008

Panel Members W. Fletcher, Reinhardt, Goodwin

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STATEMENT PURSUANT TO RULES 29 AND 35 OF THE FEDERAL RULES OF APPELLATE PROCEDURE

Petitioner Golden Gate Restaurant Association seeks en banc reconsideration and reversal of the panel decision in this case holding that the employer health care spending requirements in San Francisco's Health Care Security Ordinance ("HCSO"), S.F. Cal. Admin. Code, Ch. 14 (2006 & 2007), are not preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.*, as amended. The Secretary of Labor, who has primary authority for enforcing and administering Title I of ERISA, 29 U.S.C. §§ 1002(13), 1136(b), filed an amicus brief and presented oral argument in support of preemption, and files this brief in support of the rehearing en banc.

Rehearing en banc is appropriate under Fed. R. App. P. 35(a)(2) and (b)(1)(B) because the extent to which ERISA permits state or local governments to require employers to pay for or provide medical benefits for their employees is a question of exceptional importance due to the significant, disruptive consequences of a ruling that undermines the federal ERISA scheme by exposing employers to the complexity of complying with a potential myriad of state and local laws similar but not identical to the HCSO. Rehearing en banc is also appropriate because the panel's decision conflicts with preemption principles applied by the Supreme Court, including in *Egelhoff v. Egelhoff*, 532 U.S. 141 (2001), and by the Fourth Circuit in *Retail Industry Leaders Ass'n v. Fielder*, 475 F.3d 180 (4th Cir. 2007). *See* Fed. R. App. P. 35(b)(1)(A).

The panel decision also threatens uniformity of this Court's decisions. *See* Fed. R. App. P. 35(a)(1). In concluding that the law's City-payment option does not create an ERISA plan, the panel failed to address *Qualls v. Blue Cross of Cal.*, 22 F.3d 839, 843 (9th Cir. 1994), which held that an employer establishes an ERISA plan when it makes payments to a third-party insurer-plan administrator, and incorrectly applied a heightened test for determining when a plan exists by improperly deeming *Scott v. Gulf Oil Corp.*, 754 F.2d 1499, 1503-04 (9th Cir. 1985), to be overruled. Moreover, the panel mischaracterized the Secretary's argument. The panel viewed the Secretary as arguing that the City-run program to which employers make payments is itself an ERISA plan. Panel Op. at 13,927, 13,935. The Secretary never made that argument. Instead, the Secretary argued that when an employer chooses that option, the employer establishes an ERISA plan in the same way that the employer's payment to an insurer established a plan under Qualls.

STATEMENT

This case arose after San Francisco enacted the HCSO to provide health care for uninsured residents. *See generally* Panel Op. at 13,916; Pet. for Reh'g at 1. The law establishes a City-run Health Access Program ("HAP," now called "Healthy San Francisco") for uninsured residents and by requiring covered employers to make specified health care expenditures on behalf of their employees for each hour paid to covered employees. Current rates are $1.76 per hour for large for-profit employers, and $1.17 per hour for medium-size for-profit employers and certain non-profit employers. *Id.* § 14.1(b)(8).

The HCSO defines "health care expenditure" to mean "any amount paid by a covered employer to its covered employees or to a third party on behalf of its covered employees for the purpose of providing health care services for covered employees or reimbursing the cost of such services for its covered employees." S.F. Admin. Code § 14.1(b)(7). That definition includes payments to entities that are indisputably ERISA plans. *See* 29 U.S.C. § 1002(1), (7) (ERISA welfare benefit plan includes any plan, fund, or program providing, among other things, medical benefits to participants (employees or former employees) and their beneficiaries); Panel Op. at 13,940 ("A covered employer may choose to adopt or to change an ERISA plan" to comply with the law). The definition also includes payments to the City-run HAP to be used on behalf of covered employees. S.F. Admin. Code § 14.1(b)(7).

Golden Gate challenged the HCSO as preempted by ERISA. The district court agreed with Golden Gate that ERISA preempts the health care spending requirements. *Golden Gate Restaurant Ass'n v. City and County of San Francisco*, 535 F. Supp. 2d 968 (N.D. Cal. 2007). In January 2008, the panel stayed the district court's decision. *Golden Gate Restaurant Ass'n v. City and County of San Francisco*, 512 F.3d 1112 (9th Cir. 2008).

The Secretary filed an amicus brief supporting Golden Gate. The Secretary argued that ERISA preempts the employer spending requirements for two independent reasons: it mandates employee benefit structures or their administration, and it interferes with uniform plan administration. Sec'y Amicus Br. 8-9. On the first point, the Secretary argued that all of the options for compliance require an employer to

create or alter an ERISA plan, including the City-payment option that the panel, in its stay decision, had assumed did not require the creation or alteration of an ERISA plan. *Id.* at 9. The Secretary explained that an employer must establish an ERISA plan to comply with the City-payment option, the same way an employer establishes a plan through, among other things, purchasing group insurance. *Id.* at 13-17 (discussing, among other cases, *Qualls*, 22 F.3d at 843). On the second point, the Secretary argued that panel's stay decision, which concluded that the HCSO imposes permissible administrative burdens on employers, was incompatible with controlling precedents, record evidence, the realities of employee benefit plan administration, and the Fourth Circuit *Fielder* decision. Sec'y Amicus Br. 23.

In its decision on the merits, the panel held that ERISA does not preempt the San Francisco law. Panel Op. at 13,916, 13,924-46. The panel did not dispute the Secretary's assertion that all of the non-City payment options require an employer to create or alter an ERISA plan. The panel also concluded that if the City-payment option creates an ERISA plan, the HCSO "almost certainly makes an impermissible 'reference to' an ERISA plan." Panel Op. at 13,927. The panel, however, rejected the argument that the City-payment option requires employers to establish ERISA plans because, in its view, the administrative burdens it imposes on employers are not enough to create a plan and those burdens do not require employer discretion or run the risk of mismanagement of funds or other abuses. *Id.* at 13,927-34. Addressing an argument not previously raised by the Secretary or Golden Gate, the panel also concluded that the HAP itself is not an ERISA plan but instead is a government entitlement program funded

in part by the employer payments but primarily by taxpayer dollars and available to low- and moderate-income San Francisco residents regardless of employment status, and, as such, is beyond the reach of ERISA preemption. *Id.* at 13,934-37.

The panel also rejected the argument that the HCSO impermissibly interferes with uniform plan administration. Panel Op. at 13,938. The panel concluded that San Francisco's law is consistent with ERISA's goal of promoting plan uniformity because, based on its analysis of the City-payment option, the HCSO does not require any employer to adopt or alter an ERISA plan or require any employer to provide specific benefits through an existing ERISA plan or the HAP. *Id.* at 13,940. The panel recognized that the law may "influence[]" an employer to choose to adopt or change an ERISA plan instead of making the required health care expenditures to the City, but concluded that such an "influence" is permissible because it does not bind ERISA plan administrators to a particular choice of benefits or rules for determining plan eligibility, *id.* at 13,94041, and because the administrative burden is on the employer and not on the plan. *Id.* at 13,942.

The panel further concluded that its decision is consistent with *Fielder*. In *Fielder*, the Fourth Circuit held that ERISA preempts a Maryland law that targeted WalMart by requiring employers with 10,000 or more Maryland employees to spend at least 8% of their total payrolls on employees' health insurance costs or pay the shortfall to the state Medicaid fund. *Fielder*, 475 F.3d at 183. The panel reasoned that its decision is consistent with *Fielder* because the San Francisco law, unlike the Maryland law,

gives employers a realistic way to comply other than by creating or altering ERISA plans. *Id.* at 13,948.

ARGUMENT

Rehearing en banc should be granted because this case raises a recurring issue of exceptional importance concerning the extent to which ERISA permits recent attempts by state or local governments to require employers to pay for or provide medical benefits for their employees. *See* Supp. Excerpts of Record 49-53 (National Conference of State Legislatures listing of 2006-2007 Fair Share Health Care Fund or "Pay or Play" Bills); Pet. for Reh'g En Banc 2. Until now, the two courts that have addressed such laws have concluded that ERISA preempts them. *See Fielder*, 475 F.3d at 193-97 (4th Cir. 2007); *Retail Indus. Leaders Ass'n v. Suffolk County*, 497 F. Supp. 2d 403, 416-18 (E.D.N.Y. 2007). As Golden Gate argues, Pet. for Reh'g En Banc 2-3, the panel's contrary decision opens the door to potentially inconsistent state and local regulation of employer-provided healthcare that cannot be reconciled with ERISA's preemption, in the interest of maintaining a nationally uniform scheme of applicable legal requirements, of state and local laws that mandate employee benefit structures or their administration or that interfere with uniform plan administration. The panel's decision also threatens intra-circuit uniformity on the nature of ERISA plans and conflicts with preemption principles recognized by the Supreme Court and the Fourth Circuit's decision in *Fielder*.

Introduction

ERISA regulates the provision of health benefits by private employers. An ERISA covered plan is simply an arrangement by which private employers provide

their employees covered benefits, either directly through a self-administered plan or indirectly through a third party. 29 U.S.C. § 1002(1), (7) (definition of "welfare plan"). The purpose of ERISA's preemption provision, *id.* § 1144(a), is to ensure the primacy of the federal regulatory scheme. The San Francisco law, however, takes aim at the same conduct that ERISA regulates—private employers' provision of health benefits. S.F. Admin. Code § 14.3(a). It plainly relates to ERISA covered plans because whether and how much an employer is required to pay into the City program is directly related to whether the employer has an ERISA plan and if so the level of benefits under that plan. Consequently, it is preempted because it intrudes upon what is supposed to be an exclusively federal scheme. In holding the HCSO not to be preempted, the panel misunderstood the threshold for when an employer establishes an ERISA plan and, in conflict with the statute and prevailing precedent, set the bar for ERISA preemption substantially too high.

The panel inadequately addressed circuit precedents in its analysis of the City-payment option and mischaracterized the Secretary's position

Although it upheld San Francisco's law, the panel failed to identify any way an employer can comply with its spending requirements without creating or altering an ERISA plan, other than through the City-payment option. Whether the City-payment option requires an employer to create an ERISA plan is thus critical because, if it does, there is no question that the City's law is preempted. *See Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 16 (1987); Panel Op. at 13,927. The panel's conclusion that this option severs any possible relationship between the law and ERISA

plans, rendering the law non-preempted, not only overlooks the obvious fact that the HCSO is premised on what the City has determined to be inadequate behavior on the part of some employers in their provision of ERISA-covered health benefits to employees, but, in its analysis of the City-payment option, fails to apply the established test or reach the correct conclusion regarding whether the option itself entails the creation of ERISA plans.

The Secretary argued in support of Golden Gate that the City-payment option meets the test generally used by this and other courts to determine whether an employer has established an ERISA plan. Sec'y Amicus Br. 13-17. Under that relatively low-threshold test, a plan exists if there is an ongoing administrative program and a reasonable person can ascertain the intended benefits, beneficiaries, source of financing, and procedures for receiving benefits. *Id.* at 13 (citing *Winterrowd v. Am. Gen. Annuity Ins. Co.*, 321 F.3d 933, 939 (9th Cir. 2003)). This low-threshold test implements ERISA's objective of a uniform body of benefits law but is also central to accomplishing ERISA's remedial purposes. While it ensures the statute's broad reach it also prevents employers from sponsoring benefit programs "through the purchase of insurance or otherwise" (29 U.S.C. § 1002(1)) that evade ERISA's protective requirements merely due to a lack of formality.

The Secretary explained that when an employer chooses to fund health benefits for its employees by making payments to the City under the HAP program, the employer establishes an ERISA-covered plan for its employees, just as an employer establishes an ERISA-covered plan when it provides health benefits for its employees through the pur-

chase of insurance. *Id.* at 13-14 (citing *Qualls v. Blue Cross of Cal.*, 22 F.3d 839, 843 (9th Cir, 1994) (holding that an employer's purchase of insurance for its employees creates a plan because of the "complex ongoing relationship between the insureds and the insurer which require[s] the constant administrative attention by the insurer").

There is no relevant difference between an employer's decision to provide benefits through HAP or to provide benefits through the purchase of insurance—in both cases, the employees receive their benefits from a third party and the program is substantially administered by a third party. Nothing in the statute or the case law turns on whether the particular benefit arrangement relies upon a private insurer for the administration of benefits, rather than public employees or contractors hired by the City. Whether the employer provides benefits through private insurance or HAP, it has elected an arrangement for providing ERISA-covered benefits to its employees that meets the established test for determining whether a plan exists.

The Secretary agrees with Golden Gate that the panel erred in deviating from the generally-accepted test for determining whether a plan exists and deciding that the case from this Court originally applying that test "is almost certainly no longer good law" in light of *Fort Halifax*. Panel Op. at 13,932 (discussing *Scott*, 754 F.2d at 1503-04). As Golden Gate argues (Pet. for Reh'g 11-12), *Scott* has never been overruled, and the Supreme Court cited *Scott* without disapproval in *Fort Halifax*, 482 U.S. at 7 n.5. The Secretary and other courts of appeals have also generally accepted that test. *See, e.g.*, Sec'y Amicus Br. 13; *Kenney v. Roland Parson Contracting Corp.*, 28

F.3d 1254, 1257 (D.C. Cir. 1994) (citing cases). Indeed, as recently as 2003, in *Winterrowd*, 321 F.3d at 939, this Court reaffirmed the test; it certainly did not hold that the Scott test was no longer good law in light of *Fort Halifax*.[1]

Moreover, the panel erroneously heightened the test for determining when an "ongoing administrative scheme" exists. The Supreme Court has recognized that a state-required "benefit whose regularity of payment necessarily required an ongoing benefit program" necessarily requires administration of a plan. *Fort Halifax*, 482 U.S. at 18 n.12; *see also id.* at 14 n.9 (payment of death benefits requires a plan because "[t]he ongoing, predictable nature of this obligation therefore creates the need for an administrative scheme to process claims and pay out benefits"). The panel required not only conduct sufficient to establish or maintain a plan, but enough employer discretion in the ongoing administration of the arrangement to run the risk of employer mismanagement of funds or other employer abuse. Applying this heightened standard, the Court then concluded that an employer's obligations under the City-payment option do not present the supposedly required risks. Panel Op. at 13,931. By requiring that level of risk, however, the panel altered the standard for determining when a plan exists and failed to address

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[1] Citing dicta from *Sandstrom v. Cultor Food Science, Inc.*, 214 F.3d 795, 797 (7th Cir. 2000), the panel questioned whether the criteria for determining whether a plan exists, first established in *Donovan v. Dillingham*, 688 F.2d 1367, 1373 (11th Cir. 1982) (en banc), survive the requirement in *Fort Halifax* for an ongoing administrative scheme. Panel Op. at 13,934. That requirement is consistent with the *Dillingham* requirement for a reasonably ascertainable claims procedure. See *e.g.*, *Williams v. WCI Steel Co.*, 170 F.3d 598, 604 (6th Cir. 1999).

possible abuses that ERISA was designed to address that could result from employer choice of the City-payment option. *See* Sec'y Amicus Br. 19 (explaining that the City-payment option provides no fiduciary standards to ensure that money employers pay to the City is properly used for employee health accounts or benefits or is subject to any of the constraints imposed by ERISA to protect employees).

The panel's errors, however, run deeper. The panel simply failed to address the Secretary's argument that, under this Court's Qualls decision, a plan may exist even though a third party's responsibility for ongoing administrative activities limits the employer's actual discretion. *See Qualls*, 22 F.3d at 843. It appears that the panel incorrectly viewed the Secretary as arguing that the City-run program was itself a plan. The Secretary never made that argument. Instead, the Secretary argued that an employer who chooses the City-payment option establishes an ERISA plan "in the same manner . . . as when it provides health benefits through the purchase of insurance." Sec'y Amicus Br. 16; *see id.* at 6, 13-17. At oral argument, counsel for the Secretary specifically stated, in response to a question from the Court, that the City-run program was not an ERISA plan. *See* http://www.ca9.uscourts.gov (Audio Files, No. 07-17370, first entry, 44:45 minutes).[2] The Secretary was therefore making the same argument that Golden Gate made, i.e., that ERISA preempts the City-payment option because it requires *employers* to

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[2] Under the Secretary's view, each employer paying the City to partially fund the HAP, thereby guaranteeing its employees access to the HAP's medical benefits under favorable terms, has established a plan, but this does not mean that the HAP is an ERISA plan, making the City a plan sponsor or fiduciary, or the HAP a plan, subject to ERISA.

establish an ERISA plan. *Qualls* is an additional authority that at a minimum is in significant tension with the panel decision: no meaningful distinction can be made between a private insurer acting as a third-party administrator and a public agency or its independent contractor acting as a third-party administrator; and structuring the arrangement as a payment to a government-created entitlement program does not mean the arrangement is not a plan from the employer's perspective or carve out an exception to ERISA preemption that the statute nowhere provides.

The panel failed to apply the Supreme Court's test for determining when a state law interferes with uniform plan administration and reached a result that is inconsistent with the Fourth Circuit's Fielder decision on that issue

The Supreme Court has repeatedly explained that ERISA's preemption provision, 29 U.S.C. § 1144(a), is "intended to ensure that plans *and plan sponsors* would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives *among States* or between States and the Federal Government . . ., [and to prevent] the potential for conflict in substantive law." *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co*, 514 U.S. 645, 656 (1995) (citation omitted) (emphases added). The Supreme Court's test therefore requires an assessment not only of the burdens of the local law at issue but of the potential for conflict if other state or local governments enacted similar laws. *See, e.g.*, *Egelhoff v. Egelhoff*, 532 U.S. 141, 151 (2001). The Supreme Court's test also looks not just to potential burdens on plans and plan

administrators, but to burdens on employers in their capacity as plan sponsors. *See id.* ("This tailoring of plans *and employer conduct* to the peculiarities of the law of each jurisdiction is exactly the burden ERISA seeks to eliminate") (citation and internal quotations omitted; emphasis added).

The Secretary explained to the panel that permitting the City to enforce San Francisco's health care spending requirements creates an obvious potential for conflict with pay-or-play laws that other jurisdictions have enacted or have considered, and imposes an impermissible burden on plan sponsors and administrators to monitor, coordinate, and comply with such differing obligations. Sec'y Amicus Br. 25-28. Golden Gate made a similar argument. Appellee's Answering Br. 27-33. That potential is acute when an employer may be faced not only with having to comply with (or even keep track of) multiple state laws, but with a potentially much greater number of varying municipal laws such as the one San Francisco enacted. Even if the administrative burden imposed by a single law may be tolerable, the cumulative burden could be staggering and runs directly counter to ERISA's goal of encouraging employers, who may operate nationally, voluntarily to provide uniform employee benefits under the legal framework provided by a federal scheme with intentionally broad preemptive force.

The panel nonetheless failed to consider the potential for conflict from other pay-or-play laws. Pet. for Reh'g En Banc 14-15. Instead, it simply stated that San Francisco's HCSO does not impose "on plan administrators" any burden of complying with conflicting directives relating to benefits law, without providing any analysis of how other pay-or-play laws

may differ and interact. Panel Op. at 13,942. It also failed to consider burdens on employers as *plan sponsors*. It recognized that the law imposes burdens on employers, but decided that they are permissible because "these burdens exist whether or not a covered employer has an ERISA plan. Thus, they are burdens on the employer rather than on an ERISA plan." *Id.* Under a proper analysis, the panel should have considered the burdens the HCSO imposes on employers who already have or may establish ERISA plans (i.e., plan sponsors) and determined that it interferes with their ability to maintain plan uniformity to the extent they operate in different jurisdictions.

Accordingly, the panel's decision conflicts with the Fourth Circuit's analysis of the uniformity issue in *Fielder*. As Golden Gate explains in its rehearing petition (Pet. for Reh'g En Banc 15-16), there were two holdings in the Fourth Circuit's conclusion that ERISA preempts Maryland's Fair Share Health Care Fund Act, which required certain large employers to spend 8% of their payroll for employee health care or pay the shortfall to the state Medicaid fund. First, the court held that ERISA preempts the law because the law effectively mandated that covered employers pay for health care for their employees because no rational employer would pay the state rather than cover its own employees directly. *Fielder*, 475 F.3d at 193-94. Second, the court held that employers had no meaningful other way to pay for their employees' health care without affecting ERISA plans but even if there were a meaningful non-ERISA way to comply with the law, "we would still conclude that the Fair Share Act had an impermissible 'connection with' ERISA plans." *Id.* at 196. The court reasoned that because "the vast majority of any employer's health-

care spending occurs through ERISA plans . . . the primary subjects of the [law] are ERISA plans, and any attempt to comply with the [law] would have direct effects on the employer's ERISA plans." *Id.* The court further reasoned that "a proliferation of similar laws in other jurisdictions would force [employers] to monitor these varying laws and manipulate [their] healthcare spending to comply with them, and that such effects would deny covered employers a uniform nationwide administration of their healthcare plans." *Id.* at 197.

The panel's decision addresses only the Fourth Circuit's rejection of the state-payment option as a realistic way to comply with the Maryland law at issue in Fielder. Panel Op. at 13,946-49. However, the panel failed to address the Fourth Circuit's conclusion that even if an employer has meaningful ways to comply with a healthcare spending requirement without affecting ERISA plans, the law is still preempted because of its interference with the employer's ability to administer a uniform nationwide healthcare plan. Rehearing en banc is warranted because the panel's finding of no preemption is inconsistent with the Fourth Circuit's correct analysis on the uniformity issue.

CONCLUSION

The petition for rehearing en banc should be granted.

Respectfully submitted.

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APPENDIX D

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

No. C06-06997JSW

GOLDEN GATE RESTAURANT, ASSOCIATION,
Plaintiff,

v.

CITY AND COUNTY OF SAN FRANCISCO and DOES 1-15,
Defendants.

Now before the Court are the cross motions for summary judgment filed by Plaintiff Golden Gate Restaurant Association ("Plaintiff) and the City and County of San Francisco ("the City"). Intervenors San Francisco Central Labor Council, Service Employees International Union Local 1021, SUIU United Healthcare Workers-West and Unite-Here!, Local 2 (collectively "the Intervenors") have also moved for summary judgment on behalf of the City and have joined in the City's opposition to Plaintiffs motion. Having considered the parties' pleadings, the relevant legal authority, and having had the benefit of oral argument, the Court hereby GRANTS Plaintiffs motion for summary judgment and DENIES the City's and the Intervenors' motion for summary judgment.

BACKGROUND

In 2006, the San Francisco Board of Supervisors unanimously passed, and the Mayor signed into law, the San Francisco Health Care Security Ordinance

(the "Ordinance"). The Ordinance contains two key components related to the regulation of health care in San Francisco. The first is an employer health spending requirement and the second, is a government health care program, funded in part by those employer contributions. The employer spending requirement, which does not become operative until January 1, 2008, is the subject of the pending suit and mandates that medium and large businesses make minimum health care expenditures on behalf of covered employees. Specifically, in 2008, a private employer with between 20 and 99 employees and a nonprofit with 50 or more employees would, for any employee who has been employed for 90 days and works more than 10 hours per week, make health care expenditures of $1.17 per hour on behalf of that employee. Ord. § 14.1(b)(8); Reg. No. 5.2(A)(2). A private employer with 100 or more employees would make health care expenditures of $1.76 per hour on behalf of each covered employee. Ord. § 14(b)(8); Reg. No. 5.2(A)(1).

The Ordinance sets out a number of non-exclusive qualifying health care expenditures, such as contributions to health savings accounts, direct reimbursement to employees for some of the expenses incurred in the purchase of health care services, payments to third parties for the purpose of provided health care services, costs incurred in the direct delivery of health care services, or payments by the employer to the City "to be used on behalf of covered employees." Ord. § 14.1(b)(7).

The Ordinance also establishes a government health care program operated by the Department of Public Health. Using the expenditures paid by private employers, individuals, and contributions from

the City, the Ordinance creates a City fund to operate a Health Access Program ("HAP"). Ord. § 14.2(d). The HAP would deliver health care to its participants from a network consisting of San Francisco General Hospital, Department of Health clinics, and participating non-profit and private providers. Ord. § 14.2(a). The HAP, funded in part by the City's general fund and in part by the employer's contributions, would be available to uninsured San Francisco residents, regardless of their employment status. Enrollees would pay quarterly participation fees on a sliding scale basis. Nonresidents who work in the City would not qualify for HAP participation, but the program would set up a medical reimbursement account and those nonresident employees could draw from the account to obtain reimbursement for medical expenses, including the payment of health insurance premiums. Ord. §§ 14.1(b)(7), 14.2(g).

Employers covered by the Ordinance would be required to maintain "accurate records of health care expenditures" and "proof of such expenditures," allow "reasonable access" by City officials to such records, and annually report "such other information" that the City requires. Ord. § 14.3(b). The Ordinance also requires that all employers avoid reducing their workforce below any of the Ordinance thresholds or prove that the reduction was not done to avoid the thresholds. Ord. § 14.4(c). Violation of any of these requirements could result in significant penalties and presumptions against employers. Ord. § 14.3(b). The City would be able to collect penalties through administrative enforcement or via a civil action for penalties, costs and attorneys' fees. Ord. § 14.4(e)(3).

Golden Gate Restaurant Association, a group established to promote, extend and protect the general

interests of the restaurant industry, brought suit on November 8, 2006, seeking declaratory and injunctive relief on the theory that the Ordinance's spending requirement is preempted by ERISA. The parties cross-moved for summary judgment on that legal issue.

The Court shall address additional facts as necessary to its analysis in the remainder of this Order.

ANALYSIS

LEGAL STANDARD.

A court may grant summary judgment as to all or a part of a party's claims. Fed. R. Civ. P. 56(a). Summary judgment is proper when the "pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(c). An issue is "genuine" only if there is sufficient evidence for a reasonable fact finder to find for the non-moving party. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248-49 (1986). A fact is "material" if the fact may affect the outcome of the case. *Id.* at 248. "In considering a motion for summary judgment, the court may not weigh the evidence or make credibility determinations, and is required to draw all inferences in a light most favorable to the non-moving party." *Freeman v. Arpaio*, 125 F.3d 732, 735 (9th Cir. 1997).

A principal purpose of the summary judgment procedure is to identify and dispose of factually unsupported claims. *Celotex Corp. v. Cattrett*, 477 U.S. 317, 323-24 (1986). The party moving for summary judgment bears the initial burden of identifying those portions of the pleadings, discovery, and affidavits

which demonstrate the absence of a genuine issue of material fact. *Id.* at 323. Where the moving party will have the burden of proof on an issue at trial, it must affirmatively demonstrate that no reasonable trier of fact could find other than for the moving party. *Id.* Once the moving party meets this initial burden, the non-moving party must go beyond the pleadings and by its own evidence "set forth specific facts showing that there is a genuine issue for trial." Fed. R. Civ. P. 56(e). The non-moving party must "identify with reasonable particularity the evidence that precludes summary judgment." *Keenan v. Allan*, 91 F.3d 1275, 1279 (9th Cir. 1996) (quoting *Richards v. Combined Ins. Co.*, 55 F.3d 247, 251 (7th Cir. 1995)) (stating that it is not a district court's task to "scour the record in search of a genuine issue of triable fact"). If the non-moving party fails to make this showing, the moving party is entitled to judgment as a matter of law. *Celotex*, 477 U.S. at 323.

Whether ERISA acts to preempt a state or local law is a question of law. *Farr v. US. West Communications, Inc.*, 151 F.3d 908, 913 (9th Cir. 1998). Under the provisions of ERISA, "State law" includes "all laws, decisions, regulations, or other State action having the effect of law," while "State" includes "any political subdivisions thereof, or any agency or instrumentality of either, which purpose to regulate, directly or indirectly, the terms and conditions of em ployee benefit plans covered by [ERISA]." 29 U.S.C. §§ 1144(c)(1), (c)(2). For purposes of the analysis, "the constitutionality of local ordinances is analyzed in the same way as that of statewide laws." *Hillsborough County v. Automated Medical Laboratories, Inc.*, 471 U.S. 707, 713 (1985).

ERISA PREEMPTION.

Congress enacted the Employee Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*, as a comprehensive legislative scheme "to promote the interests of employees and their beneficiaries in employee benefit plans." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983). By enacting such a broad scheme, Congress also sought to protect employers by "eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans." *Id.* at 99. To further this goal of nationwide uniformity and consistency, Congress included a preemption clause, section 514(a), which "conspicuous for its breadth, it establishes as an area of exclusive federal concern the subject of every state law that 'relate[s] to' an employee benefit plan governed by ERISA." *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990). The clause is considered "one of the broadest preemption clauses ever enacted by Congress." *PM Group Life Insurance Co. v. Western Growers Assurance Trust*, 953 F.2d 543, 545 (9th Cir. 1992).

Section 514(a) provides that ERISA "supercede[s] any and all State laws insofar as they now or hereafter relate to any employee benefits plan." 29 U.S.C. § 1144(a). The majority of health care options provided for employees by private employers qualify as an "employee welfare benefit plan," defined by ERISA as "any plan, fund, or program which . . . was established or is maintained for the purpose of providing its participants or their beneficiaries, through the purchase of insurance or otherwise, . . . medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident [or] disability . . . . " 29 U.S.C. § 1002(1).

State laws are preempted by ERISA "insofar as they may now or hereafter relate to any employee benefit plan" regulated by ERISA. 29 U.S.C. § 1144(a). "But before a court wades into this provision's 'veritable Sargasso Sea of obfuscation,' it must first resolve the simpler question of whether a party may assert a claim under ERISA." *Miller v. Rite Aid Corp.*, 504 F.3d 1102, 1105 (9th Cir. 2007) (citing *Toumajian v. Frailey*, 135 F.3d 648, 653 n.3 (9th Cir.1998) (citation and internal quotation marks omitted)). The task of developing a clear rule to identify whether ERISA preempts a particular state law "has bedeviled the Supreme Court." *Rutledge v. Seyfarth, Shaw, Fairweather & Geraldson*, 201 F.3d 1212, 1216 (9th Cir. 2000) (citing *Dillingham*, 519 U.S. at 335) (1997) (Scalia, J., concurring) ("Since ERISA was enacted in 1974, this Court has accepted certiorari in, and decided, no less than 14 cases to resolve conflicts in the Courts of Appeals regarding ERISA pre-emption of various sorts of state law. The rate of acceptance, moreover, has not diminished . . . ") (footnote omitted)).

The language of ERISA's preemption provision—covering all laws that relate to an ERISA plan—is clearly expansive. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995). A state law relates to an ERISA employee benefit plan "if it has a connection with or reference to such a plan." *Shaw*, 463 U.S. at 97. The analysis of whether a state law is preempted by ERISA follows one of two paths—if the law is either found to be connected with or to make reference to an ERISA plan, the law is found to be preempted.

"A state law that 'relates to' an ERISA plan is preempted by ERISA even if the law is not specifi-

cally designed to affect such [a] plan . . . , or the effect is only indirect.' *Aloha Airlines v. Ahue*, 12 F.3d 1498, 1504 (9th Cir. 1993) (citing *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990)). Only those state laws that "relate to" ERISA plans are preempted. *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 23 (1987). Although the text of the ERISA preemption provision is clearly expansive, courts have recognized that the term "relate to" cannot be "taken to extend to the furthest stretch of its indeterminancy," or else "for all practical purposes preemption would never run its course." *Travelers*, 514 U.S. at 655. Indeed, "applying the 'relate to' provision according to its terms was a project doomed to failure, since, as many a curbstone philosopher has observed, everything is related to everything else." *California Division of Labor Standards Enforcement v. Dillingham Construction*, 519 U.S. 316, 335 (1997). "Some state actions may affect employee benefit plans in too tenuous, remote or peripheral a manner to warrant a finding that the law 'relates to' the plan." *Shaw*, 463 U.S. at 100 n.21; *Aloha Airlines*, 12 F.3d at 1504. Accordingly, the Court cannot rely on "uncritical literalism" but must rather attempt to ascertain whether Congress would have expected the particular statute at issue to be preempted. *Travelers*, 514 U.S. at 656.

In order to evaluate whether the normal presumption against preemption has been overcome in any particular case, the Court "must go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Id.* To determine Congressional intent, the Court must examine the "objectives of the ERISA statute" and

"the nature of the effect of the state law on ERISA plans." *Dillingham*, 519 U.S. at 325. In analyzing the basic objectives of Congress in passing the broad preemption clause of ERISA, the Supreme Court has found that the "basic thrust of the pre-emption clause [is] to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." Travelers, 514 U.S. at 657. The Court has also emphasized more generally that the "principal object of the statute [ERISA] is to protect plan participants and beneficiaries." *Boggs v. Boggs*, 520 U.S. 833, 845 (1997).

However, "the Court has established a presumption that Congress did not intend ERISA to preempt areas of traditional state regulation that are quite remote from the areas with which ERISA is expressly concerned—reporting, disclosures, fiduciary responsibility, and the like." *Rutledge*, 201 F.3d at 1217 (internal citations omitted). The Court has repeatedly held that we "must presume that Congress did not intend to preempt areas of traditional state regulation." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 740 (1985). Where "federal law is said to bar state action in fields of traditional state regulation . . . we have worked on the 'assumption that the historic police powers of the States were not to be superceded by the Federal Act unless that was the clear and manifest purpose of Congress.' *Travelers*, 514 U.S. at 655 (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)). In particular, ERISA was not intended to supplant state law, especially in cases involving "fields of traditional state regulation," which include "the regulation of matters of health and safety." *DeBuono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 814 n.8 (1997) (citations omitted). "[N]othing in the language of [ERISA] or

the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Travelers*, 514 U.S. at 662 (citing *Hillsborough County v. Automated Medical Laboratories, Inc.*, 471 U.S. 707, 719 (1985)).

However, the Supreme Court has regularly stated that the preemption clause of ERISA "indicates Congress's intent to establish the regulation of employee welfare benefit plans 'as exclusively a federal concern." *Travelers*, 514 U.S. at 656 (citing *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981)). Any state law that mandates employee benefit structures or their administration is preempted by ERISA. *Travelers*, 514 U.S. at 658. Such state-imposed regulation of employers' provision of employee benefits conflicts with ERISA's goal of establishing uniform, nationwide regulation of employee benefit plans. *Retail Industry Leaders Association v. Fielder*, 475 F.3d 180, 191 (4th Cir. 2007) (citing *Travelers*, 514 U.S. at 657-58).

The standard of whether a state law is preempted by ERISA because it makes reference to an ERISA plan applies more narrowly. The Court must examine the text of the statute to determine whether its own terms bring ERISA plans under its operation. *See Dillingham*, 519 U.S. at 325 (explaining that a state law contains a "reference to" an ERISA plan if it "acts immediately and exclusively upon ERISA plans" or if "the existence of ERISA plans is essential to the law's operation."); *see also District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 128 (1992) (invalidating a law that required an employer who provides health insurance coverage for an employee to provide the equivalent insurance while the

employee was receiving workers compensation benefits). ERISA preempts state laws that relate to employee benefit plans even if they only indirectly affect those plans. *Ingersoll-Rand*, 498 U.S. at 139.

THE ORDINANCE IS PREEMPTED BY HAVING A CONNECTION TO AND MAKING UNLAWFUL REFERENCE TO EMPLOYEE BENEFIT PLANS.

The Ordinance's health care expenditure requirements are preempted because they have an impermissible connection with employee welfare benefit plans. By mandating employee health benefit structures and administration, those requirements interfere with preserving employer autonomy over whether and how to provide employee health coverage, and ensuring uniform national regulation of such coverage. The Ordinance's provisions also make unlawful reference to benefit plans because they refer to, are designed to act immediately upon, and cannot operate successfully without the existence of employee welfare benefit plans.

ERISA was promulgated, among other reasons, to set uniform standards, including "rules concerning reporting, disclosure and fiduciary responsibility." *Shaw*, 463 U.S. at 91. The statute enables employers to adopt, modify or terminate welfare plans, in accordance with national standards, and mandates that "private parties, not the Government, control the level of benefits" under ERISA plans. *Alessi*, 451 U.S. at 511. ERISA enables private employers to set and maintain employee benefit plans in order to encourage employers to set higher benefit levels by streamlining administration and decreasing employee benefit plan costs. *Inter-Modal Rail Employees Association v. Atchison, Topeka & Santa Fe*

Railway, 520 U.S. 510, 515 (1997). Although the City contends that the Ordinance's health care expenditure requirements do not necessarily affect the levels contributed to any specific private employer's ERISA plan, the Court finds that the Ordinance affects plan administration, a core area of ERISA concern.

> (1) whether the state law regulated certain ERISA relationships, including relationships between an ERISA plan and employer and, to the extent an employee benefit plan is involved, between the employer and the employee.

The Court does not find the second factor indicates a connection between the statute and ERISA plans. Although the Ordinance's creation of the City's Health Access Program resembles an alternate ERISA plan in some ways, the Court is not persuaded that the separate public health care plan envisioned by the Ordinance actually creates a separate *de facto* ERISA plan.

Third, the requirements of the Ordinance have an impermissible connection with employee benefit plans because they impose on employers specific recordkeeping, inspection and other administrative burdens related to the administration of their private healthcare expenditures. The Ordinance requires employers to maintain accurate records of all health care expenditures, allow the City access to all such records, and provide information regarding health care expenditures to the City on an on-going basis, including "such other information" as the City may require. Ord. § 14.3(b). The Ordinance also requires the City's Office of Labor Standards Enforcement to create procedures "for covered employees to maintain accurate records" and to "provide a report to the

City." Ord. § 14.4(a). Failure by an employer to maintain accurate records, to prepare an annual report detailing employer-provided health care expenses, or to permit the audit and inspection of its records subjects an employer to substantial daily penalties. Ord. §§ 14.3(b), 14.4(e)(2).

The parties contest the extent of the administrative recordkeeping requirements and debate the complexity and extent of the necessary mathematical computations to determine compliance with the expenditure requirements. Whether the computations are complex or simple, the requirements on employers under the Ordinance are ongoing and directly affect the administrative scheme of providing healthcare benefits. *See Aloha Airlines*, 12 F.3d at 1505 (holding that state and local laws that singled out employer-provided health care costs and required reports of such costs were preempted for several reasons, including that because the state statute "creates potential reporting requirements for [the plaintiffs] ERISA plans, . . . and prompts disclosure and funding requirements, as outlined in *Shaw*, it satisfies the 'relates to' [ERISA preemption] standard."); *contra Patel v. Sugen, Inc.*, 354 F. Supp. 2d 1098, 1105 (N.D. Cal. 2005) (citing *Delaye v. Agripac, Inc.*, 39 F.3d 235, 237 (9th Cir. 1994) (no preemption where employer is required only to make a single arithmetical calculation to determine eligibility for questioned scheme)).

Lastly, the Court is persuaded that the Ordinance directly and indirectly affects the structure and administration of ERISA plans. The expenditure requirements affect the structure of private employers' already existing plans by requiring that, in order to comply with the City's additional requirements,

employers either modify the administration of their existing ERISA plans or structure their additional payments with reference to the amounts paid under the existing plans. "[E]ven if [options provided by statute] were a meaningful avenue by which [the employer] could incur non-ERISA healthcare spending, we would still conclude that the [statute] had an impermissible 'connection with' ERISA plans. The undeniable fact is that the vast majority of any employer's healthcare spending occurs through ERISA plans. Thus, the primary subjects of the [statute] are ERISA plans, and any attempt to comply with the [statute] would have direct effects on the employer's ERISA plans." Fielder, 475 F.3d at 196; *see also Egelhoff v. Egelhoff*, 532 U.S. 141, 147-48 (2001) (holding that a Washington state statute that binds ERISA plan administrators to a particular choice of rules for determining beneficiary status has an impermissible "connection with" ERISA, as the statute "implicates an area of core ERISA concern").

The requirements directly and indirectly affect the relationship between private employers and the provision of health care coverage, a relationship that has traditionally been governed by ERISA. After distilling a number of the various tests utilized in the Ninth Circuit to determine the question of preemption, the *Rutledge* court observed that under each test, "a core factor leading to the conclusion that a state law is preempted is that the claim bears on an ERISA-regulated relationship." 201 F.3d at 1219 (citing *Blue Cross of California v. Anesthesia Care Associates*, 187 F.3d 1045, 1053 (9th Cir. 1999) ("[W]e look to whether the state law encroaches on relationship regulated by ERISA . . . . "); *Emard v. Huges Aicraft Co.*, 153 F.3d 949, 957 (9th Cir. 1998) (In determining whether state law would "frustrate the

purposes" of the statute, a factor is the existence of state-law regulation of ERISA relationships.); *Operating Engineers*, 135 F.3d at 678 (A preemption factor is "whether the state law regulates certain ERISA relationships . . . . ") (quoting *Aloha Airlines, Inc.* (internal quotation marks omitted))); *Geweke Ford v. St. Joseph's Omni Preferred Care Inc.*, 130 F.3d 1355, 1358 (9th Cir. 1997) ("A state law claim is preempted if it 'encroaches on the relationships regulated by ERISA.'" (citation omitted); *see also Arizona State Carpenters Pension Trust Fund v. Citibank (Arizona)*, 125 F.3d 715, 724 (9th Cir. 1997) (holding that there is no preemption where, *inter alia*, the state laws "do not affect the relationships between the principal ERISA participants"). The Court finds that the Ordinance requires the modification of the core relationship between the private employers and their intended health care beneficiaries. In order to comply with the expenditure requirements, employers would either have modify the administration of their existing ERISA plans where the current payments are below the threshold or structure their additional payments by making unlawful reference to the amounts paid under existing ERISA plans.

Also, the Ordinance has a prohibited connection with ERISA plans because it interferes with nationally uniform plan administration. One of the principal goals of ERISA is to enable employers "to establish a uniform administrative scheme, which provides a set of claims and disbursements of benefits." *Fort Halifax Packing*, 482 U.S. at 9. Uniformity is made impossible where ERISA plans are subject to different legal obligations in different states or local jurisdictions. *Egelhoff* 532 U.S. at 148. "Requiring ERISA administrators to master the relevant laws of 50 States and to contend with litigation would

undermine the congressional goal of 'minimiz[ing] the administrative and financial burden[s]' on plan administrators—burdens ultimately borne by the beneficiaries." *Id.* at 149 (citing *Ingersoll-Rand*, 498 U.S. at 142). The "tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction" is exactly the burden ERISA seeks to eliminate. *Ingersoll-Rand*, 498 U.S. at 142. "The [statute] would deny [the employer] the uniform nationwide administration of its healthcare plans by requiring it to keep an eye on conflicting state and local minimum spending requirements and adjust its healthcare spending accordingly." *Fielder*, 475 F.3d at 197. If the expenditure requirements of the Ordinance were not considered preempted by ERISA, employers would necessarily have to keep an eye on the minimum heath care spending requirements in each locality in order to comply with potentially conflicting requirements. Mandating this type of varied compliance—both with the substantive minimum benefits levels requirements and the administrative reporting, recordkeeping and disclosure requirements—conflicts with ERISA's promise to "provide a uniform regulatory regime over employee benefit plans." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004); Shaw, 463 U.S. at 98-100.

In addition, the Court finds that the provisions of the Ordinance make unlawful reference to employee benefit plans. First, the statute specifically references the existence of ERISA plans in its expenditure requirements provisions. Ord. § 14.1(b)(7) (calculating employer liability by looking at "amounts paid by a covered employer to its covered employees or to a third party . . . for the purpose of providing health care services for covered employees."); Final Regs. § 6.2(E) (specifically referring to different types of

ERISA plans, and providing that employers do not receive credit if an employee declines coverage under a plan "that requires contributions by a covered employee."). In addition, liability under the Ordinance is determined exclusively with reference to employer-provided health benefits, mostly under existing ERISA plans, which plans are essential to the operation of the Ordinance. *See Fielder*, 475 F.3d at 196 ("The undeniable fact is that the vast majority of any employer's healthcare spending occurs through ERISA plans. Thus, the primary subjects of the [statute] are ERISA plans, and any attempt to comply with the [statute] would have direct effects on the employer's ERISA plans.") The expenditure requirements take into account directly whether and how much employers are spending on employee health coverage. The Ordinance requires that the employer examine the amounts "paid by a covered employer to its covered employees or to a third party . . . for the purpose of providing health care services for covered employees." Ord. § 14.1(b)(7). In order to enforce the spending provisions of the Ordinance, the City must examine whether employers provide ERISA-governed benefits. In order to determine compliance, the Ordinance necessarily refers to whether and how much an employer pays for employee health coverage under its existing ERISA plans, assuming such employers maintain them at all.

This Court finds that such a structure is akin to the statute the Supreme Court found preempted in *District of Columbia v. Greater Washington Board of Trade* which required the employer to provide the same amount of health care coverage for workers eligible for workers compensation. 506 U.S. at 128. The Court found that the employers' existing health care coverage was subject to ERISA and "any state

law imposing requirements by reference to such covered programs must yield to ERISA . " *Id.* at 130-31. Similarly, here, the Ordinance requires hat private employers pay a certain threshold amount to their covered employees, making specific reference to the amounts already paid through private ERISA plans. The mechanism for determining compliance with the expenditure requirements specifically takes into account the amount already spent in private plans subject to ERISA . As discussed *infra*, the structure of the private plans would necessarily be affected by the substantive expenditure requirements as well as he administration of maintaining and demonstrating compliance.

Defendants rely heavily on the decision in *WSB Electric, Inc. v. Curry*, in which the Ninth Circuit found that the two-tier approach of the California regulation of wages was not preempted by ERISA. 88 F.3d 788, 791, 796 (9th Cir. 1996). The court found that the statute which required public works contractors to pay a minimum level of cash compensation and then credited certain benefits paid by those contractors toward that level did not have an impermissible effect on ERISA plans because California's "scheme d[id] not force employers to provide any particular employee benefits . . . or to even provide . . . employee benefits at all." *Id.* at 793-94. Instead, the law gave credit for both wages and benefits when determining employers' compliance. *Id.* at 790-91; *see also Associated Builders & Contractors of S. Cal. v. Nunn*, 356 F.3d 979, 986 (9th Cir. 2004) (holding that wage statute was not preempted where rates could be satisfied by a mixture of wages and benefits). The *WSB* court distinguished the statute in *Greater Washington* which was preempted because "it imposed an obligation upon an employer that was

'measured by reference' to he level of benefit provided by that employer under an ERISA plan." *WSB*, 88 F.3d at 792-93 (citing *Greater Washington*, 506 U.S. at 128132). In contrast, the prevailing wage statute at issue in WSB merely referenced ERISA plans by taking them into account when calculating the cash wage hat must be paid to comply. *Id.* at 793. "The scheme does not force employers to provide any particular employee benefits or plans, to alter their existing plans, or to even provide ERISA plans or employee benefits at all." *Id.* (citing *Employee Staffing Services, Inc. v. Aubry*, 20 F.3d 1038, 1041 (9th Cir. 1994)). The *WSB* court held that "a statute 'refers to' an ERISA plan and is preempted if it mentions or alludes to ERISA plans, *and* has some effect on the referenced plans." *WSB*, 88 F.3d at 793.

The holding in *WSB* specifically referred to the calculation of wages, which were to include benefits as part of the total. *Id.* The Ordinance before this Court, however, would require that private employers calculate not wages but benefits available to any covered employee. Not only are these benefits the type already regulated by ERISA, but the analysis required to determine both whether an employee is covered and the amount the employee would be entitled to under the Ordinance with specific reference to amounts already paid under private ERISA plans, would alter the administration of existing private ERISA plans. As a separate spending requirement, apart from any required wages or other benefits, the Ordinance requires a certain threshold payment to ERISA plans or alternatively to the City. In addition, the Court finds that Ordinance's requirements affect the relationship between private employers and the provision of health care coverage. Therefore, according to the somewhat modified test

set out in *WSB*, the Court finds that the statute refers to ERISA plans because it both "mentions and alludes to ERISA plans, and has some effect on the referenced plans." *See id.*

Accordingly, under either analysis, the Ordinance is preempted because it has both a connection with and references ERISA plans.

CONCLUSION

For the foregoing reasons, the Court GRANTS Plaintiffs motion for summary judgment and DENIES the City's and the Intervenors' motions for summary judgment. State laws are preempted by ERISA "insofar as they may now or hereafter relate to any employee benefit plan" regulated by ERISA. 29 U.S.C. § 1144(a). The various cases interpreting the scope of ERISA preemption have established that a state law is preempted where it is related to ERISA plans, that is, where it either has a connection to or makes reference to such plans. Considering the scope of

However, as the Court noted at oral argument in this matter, the goal of providing health care for the people of San Francisco, as well as the nation, is a laudable one. On the other hand, Congress I as evinced its intent to preclude state or local governments from passing any legislation that elate to ERISA plans so as to avoid a patchwork of state and local health care programs across the nation. The Court is not convinced that other alternatives for creating a program for providing public health care are not viable. Defendants propose an increased general tax requirement, but state the unfairness of not taking existing health care expenditures into account. Without wading into the legislative dominion,

the Court can envision such a tax program that takes existing health care expenditures by private employers into account in the form of tax credits. Further, as the parties allude, there are alternatives such as funding a public health care system by requiring a hourly rate paid to the City. (*See* Intervenors' Motion at 6-7; Opp. Br. at 10 n.8.) Whatever the legislative solution to the problem facing our nation of providing adequate health care, the Court must nevertheless conclude that the San Francisco Ordinance fails to withstand the expansive test of RISA preemption.

IT IS SO ORDERED

Dated: December 26, 2007 /s/ _____
JEFFREY S. WHITE
UNITED STATES
DISTRICT JUDGE

APPENDIX E

ERISA section 2(a), 29 U.S.C. § 1001. Congressional findings and declaration of policy

(a) Benefit plans as affecting interstate commerce and the Federal taxing power. The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations; that they have become an important factor in commerce because of the interstate character of their activities, and of the activities of their participants, and the employers, employee organizations, and other entities by which they are established or maintained; that a large volume of the activities of such plans is carried on by means of the mails and instrumentalities of interstate commerce; that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans; that they substantially affect the

revenues of the United States because they are afforded preferential Federal tax treatment; that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits; and that it is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of commerce, that minimum standards be provided assuring the equitable character of such plans and their financial soundness.

ERISA section 3(1), 29 U.S.C. § 1002(1). Definitions

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise,

(A) medical, surgical, or hospital care or benefits, or benefits in the event of sick-

ness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or

(B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

ERISA section 514(a), (b), 29 U.S.C. § 1144(a), (b).
Other law

(a) Supersedure; effective date. Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in Section 4(a) and not exempt under Section 4(b). This section shall take effect on January 1, 2975.

(b) Construction and application.

(1) This section shall not apply with respect to any cause of action which arise, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

APPENDIX F

CHAPTER 14. SAN FRANCISCO HEALTH CARE SECURITY ORDINANCE

Sec. 14.1. Short Title; Definitions.

Sec. 14.2. San Francisco Health Access Program and Reimbursement Accounts.

Sec. 14.3. Required Health Care Expenditures.

Sec. 14.4. Administration and Enforcement.

Sec. 14.5. Severability.

Sec. 14.6. Preemption.

Sec. 14.7. General Welfare.

Sec. 14.8. Operative Date.

SEC. 14.1. SHORT TITLE; DEFINITIONS.

(a) Short title. This Chapter shall be known and may be cited as the "San Francisco Health Care Security Ordinance."

(b) Definitions. For purposes of this Chapter, the following terms shall have the following meanings:

(1) "City" means the City and County of San Francisco.

(2) "Covered employee" means any person who works in the City where such person qualifies as an employee entitled to payment of a minimum wage from an employer under the Minimum Wage Ordinance as provided under Chapter 12R of the San Francisco Administrative Code and has performed work for compensation for his or her employer for ninety (90) days, provided, however, that:

(a) From the effective date of this Chapter through December 31, 2007, "at least twelve (12) hours" shall

be substituted for "at least two (2) hours" where such term appears in Section 12R.3(a);

(b) From January 1, 2008 through December 31, 2008, "at least ten (10) hours" shall be substituted for "at least two (2) hours" where such term appears in Section 1 2R.3 (a);

(c) Beginning January 1, 2009, "at least eight (8) hours" shall be substituted for "at least two (2) hours" where such term appears in Section 12R.3(a);

(d) The term "employee" shall not include persons who are managerial, supervisorial, or confidential employees, unless such employees earn annually under $72,450.00 or in 2007 and for subsequent years, the figure as set by the administering agency;

(e) The term "employee" shall not include those persons who are eligible to receive benefits under Medicare or TRICARE/CHAMPUS;

(f) The term "covered employees" shall not include those persons who are "covered employees" as defined in Section 12Q.2.9 of the Health Care Accountability Ordinance, Chapter 12Q of the San Francisco Administrative Code, if the employer meets the requirements set forth in Section 12Q.3 for those employees; and

(g) The term "covered employees" shall not include those persons who are employed by a nonprofit corporation for up to one year as trainees in a bona fide training program consistent with Federal law, which training program enables the trainee to advance into a permanent position, provided that the trainee does not replace, displace, or lower the wage or benefits of any existing position or employee.

(h) Nor shall "covered employees" include those persons whose employers verify that they are receiving health care services through another employer, either as an employee or by virtue of being the spouse, domestic partner, or child of another person; provided that the employer obtains from those persons a voluntary written waiver of the health care expenditure requirements of this Chapter and that such waiver is revocable by those persons at any time.

(3) "Covered employer" means any medium-sized or large business as defined below engaging in business within the City that is required to obtain a valid San Francisco business registration certificate from the San Francisco Tax Collector's office or, in the case of a nonprofit corporation. an employer for which an average of fifty (50) or more persons per week perform work for compensation during a quarter. Small businesses are not "covered employers" and are exempt from the health care spending requirements under Section 14.3.

(4) "Employer" means an employing unit as defined in Section 135 of the California Unemployment Insurance Code or any person defined in Section 18 of the California Labor Code. "Employer" shall include all members of a "controlled group of corporations" as defined in Section 1563(a) of the United States Internal Revenue Code, and the determination shall be made without regard to Sections 1563(a)(4) and 1563 (e)(3)(C) of the Internal Revenue Code.

(5) "Health Access Program" means a San Francisco Department of Public Health program to provide health care for uninsured San Francisco residents.

(6) "Health Access Program participant" means any uninsured San Francisco resident, regardless of em-

ployment or immigration status or pre-existing condition, who is enrolled by his or her employer or who enrolls as an individual in the Health Access Program under the terms established by the Department of Public Health.

(7) "Health care expenditure" means any amount paid by a covered employer to its covered employees or to a third party on behalf of its covered employees for the purpose of providing health care services for covered employees or reimbursing the cost of such services for its covered employees, including, but not limited to (a) contributions by such employer on behalf of its covered employees to a health savings account as defined under section 223 of the United States Internal Revenue Code or to any other account having substantially the same purpose or effect without regard to whether such contributions qualify for a tax deduction or are excludable from employee income; (b) reimbursement by such covered employer to its covered employees for expenses incurred in the purchase of health care services; (c) payments by a covered employer to a third party for the purpose of providing health care services for covered employees; (d) costs incurred by a covered employer in the direct delivery of health care services to its covered employees; and (e) payments by a covered employer to the City to be used on behalf of covered employees. The City may use these payments to: (i) fund membership in the Health Access Program for uninsured San Francisco residents; and (ii) establish and maintain reimbursement accounts for covered employees, whether or not those covered employees are San Francisco residents. Notwithstanding any other provision of this subsection, "health care expenditure" shall not include any payment made directly or indi-

rectly for workers' compensation or Medicare benefits.

(8) "Health care expenditure rate" means the amount of health care expenditure that a covered employer shall be required to make for each hour paid for each of its covered employees each quarter. The "health care expenditure rate" shall be computed as follows:

(a) From the effective date of this Chapter through June 30, 2007, $1.60 per hour for large businesses and $1.06 per hour for medium-sized businesses;

(b) From July 1, 2007 through December 31, 2007, January 1, 2008 through December 31, 2008, and January 1, 2009 through December 31, 2009, the rates for large and medium-sized businesses shall increase five (5) percent over the expenditure rate calculated for the preceding year;

(c) From January 1, 2010 and each year thereafter, the "health care expenditure rate" shall be determined annually based on the "average contribution" for a full-time employee to the City Health Service System pursuant to Section A8.423 of the San Francisco Charter based on the annual ten county survey amount for the applicable fiscal year, with such average contribution prorated on an hourly basis by dividing the monthly average contribution by one hundred seventy-two (172) (the number of hours worked in a month by a full-time employee). The "health care expenditure rate" shall be seventy-five percent (75%) of the annual ten county survey amount for the applicable fiscal year for large businesses and fifty percent (50%) for medium-sized businesses.

(9) "Health care services" means medical care, services, or goods that may qualify as tax deductible

medical care expenses under Section 213 of the Internal Revenue Code, or medical care, services, or goods having substantially the same purpose or effect as such deductible expenses.

(10) "Hour paid" or "hours paid" means a work hour or work hours for which a person is paid wages or is entitled to be paid wages for work performed within the City, including paid vacation hours and paid sick leave hours, but not exceeding 172 hours in a single month. For salaried persons, "hours paid" shall be calculated based on a 40-hour work week for a full-time employee.

(11) "Large business" means an employer for which an average of one hundred (100) or more persons per week perform work for compensation during a quarter.

(12) "Medium-sized business" means an employer for which an average of between twenty (20) and ninety-nine (99) persons per week perform work for compensation during a quarter.

(13) "Person" means any natural person, corporation, sole proprietorship, partnership, association, joint venture, limited liability company, or other legal entity.

(14) "Required health care expenditure" means the total health care expenditure that a covered employer is required to make every quarter for all its covered employees.

(15) "Small business" means an employer for which an average of fewer than twenty (20) persons per week perform work for compensation during a quarter.

(Added by Ord. 218-06, File No. 051919, App. 8/4/2006; Ord. 69-07, File No. 070255, App. 4/2/2007)

SEC. 14.2. SAN FRANCISCO HEALTH ACCESS PROGRAM AND REIMBURSEMENT ACCOUNTS.

(a) The San Francisco Department of Public Health shall administer the Health Access Program. Under the Health Access Program, uninsured San Francisco residents may obtain health care from a network consisting of San Francisco General Hospital and the Department of Public Health's clinics, and other community non-profit and private providers that meet the program's quality and other criteria for participation. The Health Access Program is not an insurance plan for Health Access Program participants.

(b) The Department of Public Health shall coordinate with a third party vendor to administer program operations, including basic customer services, enrollment, tracking service utilization, billing, and communication with the participants.

(c) The Health Access Program shall be open to uninsured San Francisco residents, regardless of employment status. Eligibility criteria shall be established by the Department of Public Health, but no person shall be excluded from the Health Access Program based on a pre-existing condition. Participants may enroll themselves as individuals, with the terms of enrollment to be determined pursuant to Section 14.4(a).

(d) The Health Access Program may be funded from a variety of sources, including payments from covered employers pursuant to Section 14.3, from individuals, and from the City. Funding from the City shall prioritize services for low and moderate income persons, with costs based on the Health Access Program participant's ability to pay.

(e) The Health Access Program shall use the "Medical Home" model in which a primary care physician, nurse practitioner, or physician assistant develop and direct a plan of care for each Health Access Program participant, coordinate referrals for testing and specialty services, and monitor management of chronic conditions and diseases. Health Access Program participants shall be assigned to a primary care physician, nurse practitioner, or physician assistant.

(f) The Health Access Program shall provide medical services with an emphasis on wellness, preventive care and innovative service delivery. The Program shall provide medical services for the prevention, diagnosis, and treatment of medical conditions, excluding vision, dental, infertility, and cosmetic services. The Department of Public Health may further define the services to be provided, except that such services must, at a minimum, include: professional medical services by doctors, nurse practitioners, physician assistants, and other licensed health care providers, including preventive, primary, diagnostic and specialty services; inpatient and outpatient hospital services, including acute inpatient mental health services; diagnostic and laboratory services, including therapeutic radiological services; prescription drugs, excluding drugs for excluded services; home health care; and emergency care provided in San Francisco by contracted providers, including emergency medical transportation if needed.

(g) The Department of Public Health shall also be authorized to use payments made to the City by employers to satisfy their expenditure requirements as set forth in Section 14.3 to establish and maintain reimbursement accounts from which covered em-

ployees may obtain reimbursement of health care expenditures.

(h) The City Controller shall ensure any required health care expenditures made by an employer to the City are kept separate and apart from general funds and shall limit use of the expenditures to the Health Access Program or to the establishment and maintenance of reimbursement accounts from which covered employees may obtain reimbursement of health care expenditures. If any covered employee fails to enroll in the Health Access Program or establish a reimbursement account with the Department of Public Health within a reasonable time, as determined by the Department of Public Health, the City may use the funds paid to the City and County of San Francisco on behalf of that employee for the benefit of the health care programs created by this Ordinance, but the City may not transfer these funds to the City's general fund.

(Added by Ord. 218-06, File No. 051919, App. 8/4/2006; Ord. 69-07, File No. 070255, App. 4/2/2007)

SEC. 14.3. REQUIRED HEALTH CARE EXPENDITURES.

(a) Required Expenditures. Covered employers shall make required health care expenditures to or on behalf of their covered employees each quarter. The required health care expenditure for a covered employer shall be calculated by multiplying the total number of hours paid for each of its covered employees during the quarter (including only hours starting on the first day of the calendar month following ninety (90) calendar days after a covered employee's date of hire) by the applicable health care expenditure rate. In determining whether a covered

employer has made its required health care expenditures, payments to or on behalf of a covered employee shall not be considered if they exceed the following amount: the number of hours paid for the covered employee during the quarter multiplied by the applicable health care expenditure rate. The City's Office of Labor Standards Enforcement (OLSE) shall enforce the health expenditure requirements under this Section.

(b) Additional Employer Responsibilities. A covered employer shall: (i) maintain accurate records of health care expenditures, required health care expenditures, and proof of such expenditures made each quarter each year, and allow OLSE reasonable access to such records, provided, however, that covered employers shall not be required to maintain such records in any particular form; and (ii) provide information to the OLSE, or the OLSE's designee, on an annual basis containing such other information as OLSE shall require, but OLSE may not require an employer to provide information in violation of State or federal privacy laws. Where an employer does not maintain or retain adequate records documenting the health expenditures made, or does not allow OLSE reasonable access to such records, it shall be presumed that the employer did not make the required health expenditures for the quarter for which records are lacking, absent clear and convincing evidence otherwise. The Office of Treasurer and Tax Collector shall have the authority to provide any and all nonfinancial information to OLSE necessary to fulfill the OLSE's responsibilities as the enforcing agency under this Ordinance. With regard to all such information provided by the Office of Treasurer and Tax Collector, OLSE shall be subject to the confidentiality provisions of Subsection (a) of Section

6.22-1 of the San Francisco Business and Tax Regulations Code.

(Added by Ord. 218-06, File No. 051919, App. 8/4/2006; Ord. 69-07, File No. 070255, App. 4/2/2007)

SEC. 14.4. ADMINISTRATION AND ENFORCEMENT.

(a) The City shall develop and promulgate rules to govern the operation of this Chapter. The regulations shall include specific rules by the Department of Public Health on the operation of both the Health Access Program and the reimbursement accounts identified in Section 14.2(g), including but not limited to eligibility for enrollment in the Health Access Program and establishment of reimbursement accounts and rules by the OLSE for enforcement of the obligations of the employers under this Chapter. The rules shall also establish procedures for covered employers to maintain accurate records of health care expenditures and required health care expenditures and provide a report to the City without requiring any disclosures of information that would violate State or Federal privacy laws. The rules shall further establish procedures for providing employers notice that they may have violated this Chapter, a right to respond to the notice, a procedure for notification of the final determination of a violation, and an appeal procedure before a hearing officer appointed by the City Controller. The sole means of review of the hearing officer's decision shall be by filing in the San Francisco Superior Court a petition for a writ of mandate under Section 1094.5 of the California Code of Civil Procedure. No rules shall be adopted finally until after a public hearing.

(b) During implementation of this Chapter and on an ongoing basis thereafter, the City shall maintain an education and advice program to assist employers with meeting the requirements of this Chapter.

(c) Any employer that reduces the number of employees below the number that would have resulted in the employer being considered a "covered employer," or below the number that would have resulted in the employer being considered a medium-sized or large business, shall demonstrate that such reduction was not done for the purpose of evading the obligations of this Chapter or shall be in violation of the Chapter.

(d) It shall be unlawful for any employer or covered employer to deprive or threaten to deprive any person of employment, take or threaten to take any reprisal or retaliatory action against any person, or directly or indirectly intimidate, threaten, coerce, command or influence or attempt to intimidate, threaten, coerce, command or influence any person because such person has cooperated or otherwise participated in an action to enforce, inquire about, or inform others about the requirements of this Chapter. Taking adverse action against a person within ninety (90) days of the person's exercise of rights protected under this Chapter shall raise a rebuttable presumption of having done so in retaliation for the exercise of such rights.

(e) (1) The City shall enforce the obligations of employers and covered employers under this Chapter, and may impose administrative penalties upon employers and covered employers who fail to make required health care expenditures on behalf of their employees. The amount of the penalty shall be up to one-and-one-half times the total expenditures that a covered employer failed to make plus simple annual

interest of up to ten (10) percent from the date payment should have been made, but in any event the total penalty for this violation shall not exceed $1,000.00 for each employee for each week that such expenditures are not made.

(2) For other violations of this Chapter by employers and covered employers, the administrative penalties shall be as follows: For refusing to allow access to records, pursuant to Section 14.3(b), $25.00 as to each worker whose records are in issue for each day that the violation occurs; for the failure to maintain or retain accurate and adequate records pursuant to Section 14.3(b) and for the failure to make the annual report of information required by OLSE pursuant to Section 14.3(b). $500.00; for violation of Section 14.4(d) (retaliation), $100.00 as to each person who is the target of the prohibited action for each day that the violation occurs; and for any other violation not specified in this subsection (e)(2), $25.00 per day for each day that the violation occurs.

(3) The City Attorney may bring a civil action to recover civil penalties for the violations set forth in subsections (e)(1) and (e)(2) in the same amounts set forth in those subsections, and to recover the City's enforcement costs, including attorneys' fees.

(4) Amounts recovered under this Section shall be deposited in the City's General Fund.

(f) The City Controller shall coordinate with the Department of Public Health and OLSE to prepare periodic reports on the implementation of this Chapter including participant rates, any effect on services provided by the Department of Public Health, the cost of providing services to the Health Access Program participants and the economic impact of the

Chapter's provisions. Reports shall be provided to the Board of Supervisors on a quarterly basis for quarters beginning July 1, 2007 through June 30, 2008, then every six months through June 30, 2010. Reports shall include specific information on any significant event affecting the implementation of this Chapter and also include recommendations for improvement where needed, in which case the Board of Supervisors or a committee thereof shall hold a hearing within thirty (30) days of receiving the report to consider responsive action.

(g) The Director of Public Health shall convene an advisory Health Access Working Group to provide the Department of Public Health and the Health Access Program with expert consultation and direction, with input on members from the Mayor and the Board of Supervisors. The Health Access Working Group shall be advisory in nature and may provide the Health Access Program with input on matters including: setting membership rates; designing the range of benefits and health care services for participants; and researching utilization, actuaries, and costs.

(h) The Department of Public Health and the OLSE shall report to the Board of Supervisors by July 1, 2007, on the development of rules for the Health Access Program and for the enforcement and administration of the employer obligations under this Chapter. The Board of Supervisors or a committee thereof shall hold a hearing on the proposed rules to ensure that participants in the Health Access Program shall have access to high quality and culturally competent services.

(Added by Ord. 218-06, File No. 051919, App. 8/4/2006; Ord. 69-07, File No. 070255, App. 4/2/2007)

SEC. 14.5. SEVERABILITY.

If any section, subsection, clause, phrase, or portion of this Chapter is for any reason held invalid or unconstitutional by any court or Federal or State agency of competent jurisdiction, such portion shall be deemed a separate, distinct and independent provision and such holding shall not affect the validity of the remaining portions thereof. To this end, the provisions of this ordinance shall be deemed severable.

(Added by Ord. 218-06, File No. 051919, App. 8/4/2006)

SEC. 14.6. PREEMPTION.

Nothing in this Chapter shall be interpreted or applied so as to create any power, duty or obligation in conflict with, or preempted by, any Federal or State law.

(Added by Ord. 218-06, File No. 051919, App. 8/4/2006)

SEC. 14.7. GENERAL WELFARE.

By this Chapter, the City is assuming an undertaking only to promote the general welfare and otherwise satisfy its obligations to provide health care under applicable law. This Chapter should in no way be construed as an expansion of the City's existing obligations to provide health care under State and Federal law, and the City shall set all necessary criteria for enrollment consistent with its legal obligations. The City is not assuming, nor is it imposing on its officers and employees, an obligation for breach of which it is liable in money damages to any person who claims that such breach proximately caused injury. To the fullest extent permitted by law, the City shall assume no liability whatsoever. To the fullest extent permitted by law, any actions taken by a public officer or employee under the provisions of

this Chapter shall not become a personal liability of any public officer or employee of the City.

(Added by Ord. 218-06, File No. 051919, App. 8/4/2006)

SEC. 14.8. OPERATIVE DATE.

This Chapter shall become operative in three phases. The day this Chapter becomes effective, implementation of the Chapter shall commence. The Health Access Program shall become operative on July 1, 2007. Any requirements on employers for which an average of fifty (50) or more persons per week perform work for compensation during a quarter shall become operative on January 1, 2008. Any requirements on employers for which an average of from twenty (20) to forty-nine (49) persons per week perform work for compensation during a quarter shall become operative on April 1, 2008. This Chapter is intended to have prospective effect only.

(Added by Ord. 218-06, File No. 051919, App. 8/4/2006; Ord. 72-07, File No. 070354, App. 4/2/2007)

APPENDIX G

CITY AND COUNTY OF SAN FRANCISCO
OFFICE OF LABOR STANDARDS ENFORCEMENT

Donna Levitt, Manager

REGULATIONS IMPLEMENTING THE EMPLOYER SPENDING REQUIREMENT OF THE SAN FRANCISCO HEALTH CARE SECURITY ORDINANCE (HCSO)

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OLSE Regulations Implementing the Employer Spending Requirement of the San Francisco health Security Ordinance (HCSO)

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For specific inquiries regarding the HCSO, please call (415) 554-7892 or email HCSO@sfgov.org.

INTRODUCTION

The Office of Labor Standards Enforcement ("OLSE") promulgates these Regulations pursuant to Chapter 2A, Article 1, Section 2A.23 and Chapter 14 of the San Francisco Administrative Code. Pursuant to Chapter 14, the San Francisco Health Care Security Ordinance ("HCSO"), the OLSE is mandated to enforce the Employer Spending Requirement of the HCSO.

From February 1 through July 17, 2006, and again on March 7 and May 8, 2007, the Board of Supervisors held 19 hearings at which there were opportunities for public comment on the HCSO and its amendments. In January and June of 2007, the OLSE issued draft Regulations, which were vetted through a public process that included public hearings and the opportunity to provide both oral and written comments and updated several times based upon public input.

In developing these Regulations, the OLSE has been guided by its understanding of the importance of fulfilling the goals of the Ordinance, providing clear direction to employers and employees, and giving weight to considerations of equity and practicality.

Fulfilling the goals of the Ordinance. In developing these Regulations, the OLSE has tried to be faithful to the basic goals of the Ordinance. These goals are well established. The Ordinance and its amendments include extensive statements of legislative findings and purpose, explaining the multiple rationales for the Ordinance and articulating its goals. These statements of legislative findings and purpose is found in Sections 1 of the Ordinance and Amended

Ordinance, and, as such, have the full force and effect of law. Particularly in light of the statements of legislative findings and purpose, the Ordinance should be liberally construed to effect its goals.

Providing clear direction to employers and employees. In mandating the OLSE to promulgate regulations on the Employer Spending Requirement of the Ordinance, the Board of Supervisors intended that the OLSE provide clear direction to employers and employees upon which they could rely. (See S.F. Admin. Code § 14.4(a).) Accordingly, these Regulations seek to fulfill that mandate.

Giving weight to considerations of equity and practicality. Finally, in adopting the Ordinance, the Board of Supervisors intended that guidelines or regulations take into account considerations of equity and practicality, from both the employee and employer perspective. Accordingly, these Regulations are designed to be both fair and workable for employees and employers alike. One aspect of the Regulations, though not a dominant feature, is to reduce the possibility of abuses by employees and employers.

While these principles have guided the OLSE's judgment in developing these Regulations, it must be acknowledged that general principles do not always automatically yield a single, specific result with respect to a particular Regulation. Multiple and sometimes conflicting considerations come into play in the development of a Regulation. Having been authorized by the Ordinance to promulgate these Regulations, the OLSE ultimately must exercise its judgment in developing Regulations that are reasonable in light of all relevant factors, taking into account both input from the public and its own expertise as a labor standards enforcement office.

REGULATION 1: EMPLOYER SPENDING REQUIREMENT

1.1 Employer Spending Requirement

(A) Each quarter, covered employers are required to make qualifying health care expenditures:

(1) to their covered employees, or

(2) for the benefit of their covered employees.

For the definition of qualifying health care expenditures, *see* Regulation 4.

1.2 Definition of Quarter

A quarter shall be defined as one of four three-month periods in a calendar year. Thus, the first quarter of the year shall be defined as the period from January 1 through March 31; the second quarter shall be the period from April 1 through June 30; the third quarter, the period from July 1 through September 30; and the fourth quarter, the period from October 1 through December 31.

For timing and manner of payment of the Employer Spending Requirement, *see* Regulation 6.2.

REGULATION 2: COVERED EMPLOYERS

2.1 Definition of Employer

An employer is an employing unit as defined in Section 135 of the California Unemployment Insurance Code or any person defined in Section 18 of the California Labor Code. An employer includes all members of a "controlled group of corporations" as defined in Section 1563(a) of the United States Internal Revenue Code, and the determination shall be made without regard to Sections 1563(a)(4) and 1563(e)(3)(C) of the Internal Revenue Code.

2.2 Covered Employer

(A) A "covered employer" is:

(1) any Medium-size or Large Business, as defined in subsection C below, that;

(2) engages in business within the City and is required to obtain a valid San Francisco business registration certificate pursuant to Article 12 of the Business and Tax Regulations Code.

(B) Whether an employer is physically located within the geographic boundaries of the City and County of San Francisco has no bearing on whether it meets the definition of a "covered employer." (In contrast, however, only persons who work for a covered employer within the geographic boundaries of the City and County of San Francisco may be considered "covered employees." *See* Regulation 3.)

(C) The law defines three categories of employers:

(1) Large Business: an employer for which an average of 100 or more persons per week perform work for compensation during a quarter. This category shall include nonprofit corporations for which an average of 100 or more persons per week perform work for compensation during a quarter.

(2) Medium-size Business: an employer for which an average of 20 to 99 persons per week perform work for compensation during a quarter. This category shall include only those nonprofit corporations for which an average of 50 to 99 persons per week perform work for compensation during a quarter.

(3) Small Business: an employer for which an average of 19 or fewer persons per week perform work for compensation during a quarter.

(D) For the purposes of determining employer size, the term "persons":

(1) shall include all employees, regardless of their status or classification as seasonal, permanent or temporary, full-time or part-time, contracted (whether employed directly by the employer or through a temporary staffing agency, leasing company, professional employer organization, or other entity) or commissioned;

(2) shall not be limited to covered employees, as defined in Regulation 3; and

(3) shall include both those who work within San Francisco and those who work outside of San Francisco.

(E) For businesses employing a fluctuating number of employees during a quarter, employer size will be determined based on the average number of persons per week performing work for compensation during the applicable quarter.

(F) Effective Dates of Coverage

(1) This law shall be effective on January 1, 2008 for all employers for which an average of 50 or more persons per week perform work for compensation during a quarter.

(2) This law shall become effective April 1, 2008 for all for-profit businesses for which an average of 20 or more persons per week perform work for compensation during a quarter.

(3) Non-profit Medium-size Businesses for which an average of 49 or fewer persons per week perform work for compensation during a quarter and all Small Businesses are exempt from the requirements of this Ordinance.

REGULATION 3: COVERED EMPLOYEES

3.1 Covered Employees

(A) A covered employee is any person who:

(1) qualifies as an employee entitled to payment of minimum wage pursuant to the Minimum Wage Ordinance, Chapter 12R of the San Francisco Administrative Code;

(2) has been employed by his or her employer for 90 calendar days after his or her first day of work (including any period of leave to which an employee is legally entitled); and,

(3) in a particular week performs at least the number of hours of work specified below:

(a) Beginning January 1, 2008: in a particular week performs at least 10 hours of work for the employer within the geographic boundaries of the City and County of San Francisco.

(b) Beginning January 1, 2009: in a particular week performs at least 8 hours of work for the employer within the geographic boundaries of the City and County of San Francisco.

(c) For employees whose work hours fluctuate from week to week, eligibility will be determined based on the average number of hours worked per week during the applicable quarter.

(B) 90-Calendar-Day Eligibility Period. The 90-calendar-day eligibility period need not be continuous, consecutive, nor completed in the same calendar year.

(1) For an employee who is separated from employment prior to completing the eligibility period, the prior days of employment shall count towards the

eligibility period if the employee returns to work within one (1) year of the most recent separation date.

(2) An employee who is separated from employment after completing the eligibility period shall not be required to complete a new eligibility period, if the employee is rehired within one (1) year of the most recent separation date.

(C) Work Performed "Within" the City and County of San Francisco

(1) While employees who travel through San Francisco in the performance of their job duties shall not be considered to have performed work in San Francisco, an employee whose work requires stops in San Francisco (for example, to make pick-ups or deliveries) shall be considered to have performed work in San Francisco. For these employees, hours worked shall include travel within the geographic boundaries of the City and County of San Francisco. *See* Regulation 6.1(C)(1)(c).

(2) Work performed on city-owned or city-leased property outside the geographic boundaries of the City and County of San Francisco shall not be considered in meeting the hours requirement in Regulation 3.1(A)(3).

(3) For employees who live in San Francisco, work performed for a covered employer from the employee's own home, including telecommuting, shall qualify as work performed "within" the City and County of San Francisco.

(D) An employee's status or classification as seasonal, permanent or temporary, full-time or part-time, exempt or non-exempt, salaried or hourly, or contracted (whether employed directly by the em-

ployer or through a temporary staffing agency, leasing company, professional employer organization, or other entity) or commissioned shall not be considered in determining whether that employee is a covered employee.

(E) Employees made available to work through the services of a temporary staffing agency, leasing agency, professional employer organization, or other entity serving the same or similar function may or may not be considered employees of such entity. Both the client and the temporary staffing, leasing, professional employer, or similar entity may be considered an employer under this Ordinance, and each party shall have an obligation to ensure that the Employer Spending Requirement is met.

(F) Whether an employee is simultaneously employed by more than one employer shall not impact a covered employer's responsibilities under this law.

3.2 Covered Employee Exemptions

(A) The following persons are not covered employees under the HCSO:

(1) Persons who are managerial, supervisory, or confidential employees, unless such employees earn under $74,558 annually (or $35.85 hourly) in 2007. For each year thereafter, this figure shall increase by an amount corresponding to the prior year's increase, if any, in the Consumer Price Index for urban wage earners and clerical workers for the San Francisco-Oakland-San Jose metropolitan statistical area in California. For purposes of this exemption category,

(a) "managerial employee" is defined as an employee who has authority to formulate, determine, or effectuate employer policies by expressing and mak-

ing operative the decisions of the employer and who has discretion in the performance of his/her job independent of the employer's established policies;

(b) "supervisory employee" is defined as an employee who has authority, in the interest of the employer, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or the responsibility to direct them, or to adjust their grievances, or effectively to recommend any such action, if the exercise of this authority or responsibility is not of a merely routine or clerical nature, but requires the use of independent judgment;

(c) "confidential employee" is defined as an employee who acts in a confidential capacity to formulate, determine, and effectuate management policies with regard to labor relations, or regularly substitutes for employees having such duties.

(2) Persons who are eligible to receive benefits under Medicare (as distinguished from Medicaid/Medi-Cal) or TRICARE/CHAMPUS (the federal health care and health benefits program for active duty and retired members of the uniformed services, their families, and survivors);

(3) Persons who are "covered employees" as defined in Section 12Q.2.9 of the San Francisco Administrative Code (Health Care Accountability Ordinance), if the employer meets the requirements set forth in Section 12Q.3 of the San Francisco Administrative Code for those employees;

(4) Persons who are employed by a non-profit corporation for up to one year as trainees in a bona fide training program consistent with federal law, which training program enables the trainee to ad-

vance into a permanent position, provided that the trainee does not replace, displace, or lower the wage or benefits of any existing position or employee;

(5) Persons who provide verification that they are receiving health care services through another employer, either as an employee or by virtue of being the spouse, domestic partner, or child of another person - provided that the employer obtains from those persons a voluntary written waiver of the health care expenditure requirements of the HCSO as follows. The employer must make its required health care expenditures on behalf of the employee unless all of the following requirements are met:

(a) Employers must use the Employee Voluntary Waiver Form provided in Appendix A.

i. The form must be voluntarily completed by the employee without pressure or coercion from the employee's coworkers or the employer, including, supervisor(s), manager(s), or their agents.

ii. An employee waiver is valid for one year, at which point a new waiver must be signed.

iii. Employees reserve the right to revoke their voluntary waiver at any time; however, the revocation must be submitted in writing.

iv. Employers must provide the employee with a complete copy of the Voluntary Waiver Form.

v. An electronic copy of the Voluntary Waiver Form shall be acceptable, provided that the employee receive a hard copy of any form(s) signed by the employee and the employee is readily able to access copies of such forms.

(b) Employers must maintain in their records a Voluntary Waiver Form signed by each employee for

whom the employer seeks to claim an exemption from the requirements of the HCSO, including information regarding the type and source of coverage (e.g., health insurance provided through the employer of the employee's spouse), as specified on the Voluntary Waiver Form, updated annually.

REGULATION 4: HEALTH CARE EXPENDITURES

4.1 Definition of Health Care Expenditure

(A) A health care expenditure is any amount paid by a covered employer to its covered employees or to a third party on behalf of its covered employees for the purpose of providing health care services for covered employees or reimbursing the cost of such services for its covered employees.

(B) Health care services means medical care, services, or goods that may qualify as tax deductible medical care expenses under Section 213 of the Internal Revenue Code, or medical care, services, or goods having substantially the same purpose or effect as such deductible expenses. Qualifying medical expenses include dental treatments and fees paid to dentists for x-rays, fillings, braces, extractions, dentures, and the like; eyeglasses and contact lenses needed for medical reasons; and fees for eye examinations and eye surgery to treat defective vision.

4.2 Examples of Qualifying Health Care Expenditures

(A) Each covered employer has discretion as to the type of health care expenditure it chooses to make for its covered employees. Examples of health care expenditures include, but are not limited to:

(1) Payments to a third party to provide health care services for a covered employee, e.g., health insurance premiums;

(2) Expenditures made by self-insured and/or self-funded insurance programs;

(3) Contributions on behalf of a covered employee to a health benefit flexible spending account, a health savings account, a health reimbursement account, a medical spending account (as defined under sections 125, 223 of the federal Internal Revenue Code and Publication 969 of the Internal Revenue Service), or to any other account having substantially the same purpose or effect without regard to whether such contributions qualify for a tax deduction or are excludable from employee income;

(4) Reimbursement to a covered employee for expenses incurred in the purchase of health care services;

(5) Costs incurred in the direct delivery of health care services for a covered employee; and,

(6) Payments on behalf of a covered employee to the City of San Francisco:

(a) to fund membership in the Health Access Program/Healthy San Francisco; or

(b) to establish and maintain medical reimbursement accounts for covered employees.

(B) Health care expenditures shall not include any payment made directly or indirectly to obtain workers' compensation, State Disability Insurance, Social Security, Medicare, or any other coverage required by any other local, state, or federal law.

(1) Prevailing Wage/Public Works Contracts. Payment of the prevailing wage fringe benefit re-

quirement in cash (as part of the covered employee's paycheck or otherwise) shall not satisfy the Employer Spending Requirement of this Ordinance.

(C) Employer health care expenditures shall include administrative costs paid to a third party for the purpose of providing health care services for covered employees, but shall not include administrative costs incurred by the employer, but not paid to a third party. Such costs are properly considered a business expense of the employer.

(D) Health care expenditures made on behalf of a covered employee for the benefit of his or her domestic partner, spouse, family member, or other dependent shall be included in determining whether an employer has met its required expenditure to or on behalf of the covered employee.

4.3 Other Qualifying Health Care Expenditures

Qualifying health care expenditures shall not be limited to those that qualify as tax deductible medical care expenses under Section 213 of the Internal Revenue Code and Publication 502 of the Internal Revenue Service, but may include medical care, services, or goods having substantially the same purpose or effect. Examples of qualifying expenditures include vision and dental coverage; nonprescription drugs, including, but not limited to, antacids, allergy medicines, pain relievers, and cold medicines; doctor's fees; and necessary hospital services not paid for by insurance.

REGULATION 5: HEALTH CARE EXPENDITURE RATES

5.1 Definition of Health Care Expenditure Rate

The health care expenditure rate is the amount of health care expenditure that a covered employer is

required to make for each hour paid for each of its covered employees during a quarter.

5.2 Health Care Expenditure Rates

(A) The health care expenditure rate for a covered employer is determined by that employer's size:

(1) Large Business. Beginning January 1, 2008, Large Businesses for which an average of 100 or more persons per week perform work for compensation during a quarter are required to make a health care expenditure of $1.76 per hour for each hour paid for each of its covered employees.

(2) Medium-Size Business

(a) Beginning January 1, 2008, Medium-size Businesses for which an average of 50-99 persons per week perform work for compensation during a quarter are required to make a health care expenditure of $1.17 per hour for each hour paid for each of its covered employees.

(b) Beginning April 1, 2008, all Medium-size Businesses (including those for which an average of 20-49 persons per week perform work for compensation during a quarter), except nonprofit corporations exempt from the definition of a covered employer, are required to make a health care expenditure of $1.17 per hour for each hour paid for each of its covered employees.

(B) Increases to Health Care Expenditure Rates

(1) For all covered businesses, the health care expenditure rate will be increased by 5% on January 1, 2009. Through 2009, the employer health care expenditure rate is as follows:

(2) From January 1, 2010 and each year thereafter, the "health care expenditure rate" shall be de-

termined annually based on the "average contribution" for a full-time employee to the City Health Service System pursuant to Section A8.423 of the San Francisco Charter based on the annual ten-county survey amount for the applicable fiscal year, with such average contribution prorated on an hourly basis by dividing the monthly average contribution by one hundred seventy-two (172) (the number of hours worked in a month by a full-time employee). The "health care expenditure rate" shall be seventy-five percent (75%) of the annual ten-county survey amount for the applicable fiscal year for large businesses and fifty percent (50%) for medium-sized businesses. Beginning in 2009 and in each year thereafter, the OLSE shall publish, by March 1, the adjusted expenditure rates for the upcoming calendar year

REGULATION 6: CALCULATING & MAKING HEALTH CARE EXPENDITURES

6.1 Calculating Health Care Expenditures

(A) A covered employer's required health care expenditure is the sum of the health care expenditure that the covered employer is required to make each quarter for each of its covered employees.

(B) The required health care expenditure is calculated by multiplying the total number of "hours paid," as defined below, to each covered employee during the quarter (starting on the first day of the calendar month following 90 calendar days after a covered employee's first day of work) by the applicable health care expenditure rate specified in Regulation 5.2.

(C) The required health care expenditures are based on hours paid, which may or may not be hours actually worked. "Hours paid" includes both hours

for which a person is paid wages for work performed within San Francisco and hours for which a person is entitled to be paid wages, including, but not limited to, paid vacation hours, paid time off, and paid sick leave hours, but not exceeding 172 hours in a single month or 516 hours in a single quarter.

(1) Work Performed and "Hours Paid" within San Francisco

(a) Any work performed by covered employees within San Francisco must be tracked by the employer. Unless there is clear and convincing evidence otherwise, all hours worked by covered employees will be presumed to be for work performed within San Francisco.

(b) For covered employees who perform some work outside of San Francisco, "hours paid" that are not hours actually worked (e.g., paid vacation hours, paid time off, and paid sick leave hours) will be calculated on a pro rata basis.

(c) Employees whose work requires stops in San Francisco (for example, to make pick-ups or deliveries) shall be considered to be performing work in San Francisco, and their "hours worked" shall include travel within the City and County of San Francisco.

(d) For covered employees who live in San Francisco and perform work for a covered employer from the employee's own home, including telecommuting, "hours worked" shall include all hours worked from home.

6.2 Timing and Manner of Health Care Expenditures

(A) The required health care expenditure must be made regularly, and no later than 30 days after the end of the preceding quarter.

(1) Employers meeting the requirements of the limited exception outlined in Regulation 6.2(B)(2) shall not be required to make expenditures under such plans quarterly.

(2) Nothing in this regulation shall prevent an employer from making regular expenditures prospectively, or before the end of a quarter, in order to obtain health care or health coverage for a covered employee during such quarterly period.

(B) Subject to the following limited exceptions, covered employers must make health care expenditures to or on behalf of each covered employee. Ordinarily, payments to or on behalf of one covered employee that exceed the required health expenditure for that employee will not be included in determining whether an employer has met its total required health care expenditures for all employees. However:

(1) A covered employer that provides uniform health coverage to some or all of its covered employees shall, with respect to those employees, be deemed to comply with the spending requirement of this Ordinance if the average expenditure rate per employee meets or exceeds the applicable expenditure rate (outlined in Regulation 5) for that employer.

(2) A covered employer that provides health coverage to some or all of its covered employees through a self-funded/self-insured plan shall, with respect to those employees, be deemed to comply with the spending requirement of this Ordinance if the preceding year's average expenditure rate per employee meets or exceeds the applicable expenditure rate (outlined in Regulation 5) for that employer.

(3) The average expenditure rate shall be calculated by dividing the total amount of health care ex-

penditures made for such employees by the total number of hours paid to such employees.

(C) An employer may choose more than one option to satisfy its duty to make the required health care expenditures for one or more of its covered employees. An employer may, for example, choose to purchase health insurance for its full-time employees, but make payment to the City to fund part-time employees' membership in the Health Access Program/Healthy San Francisco.

(D) The required health care expenditure must be made in full each quarter. Thus, an employer who purchases a health insurance program with premiums that are less than the required expenditure must choose a second option to make the expenditure in full. For example, the employer may choose to pay the remainder to the City to establish and maintain medical reimbursement accounts for such employees.

(E) A covered employer that maintains a health care program that requires contributions by a covered employee shall not have satisfied its obligation to make the required health care expenditures merely by offering a covered employee the opportunity to participate in such a program. Should the employee decline to participate in such a program, the employer shall not have satisfied its obligation to make the required health care expenditures.

REGULATION 7: ADDITIONAL EMPLOYER RESPONSIBILITIES

7.1 Employer Notice to Employee of Payment to the City

A covered employer who satisfies its obligation to make the required health care expenditures by making payment to the City shall provide its covered

employees with notice, using the form provided in Appendix B.

7.2 Employer Recordkeeping

(A) Covered employers shall keep, or cause to be kept, for a period of four years from the covered employees' dates of employment:

(1) itemized pay statements, as mandated by California Labor Code Section 226, which requires the following: (a) gross wages earned, (b) total hours worked by the employee (unless salaried), (c) the number of piece-rate units earned and any applicable piece rate if the employee is paid on a piece-rate basis, (d) all deductions, aggregated, (e) net wages earned, (f) the inclusive dates of the period for which the employee is paid, (g) the name of the employee and his or her social security number/the last four digits of his or her social security number or an employee identification number other than a social security number may be shown on the itemized statement, (h) the name and address of the legal entity that is the employer, and (i) all applicable hourly rates in effect during the pay period and the corresponding number of hours worked at each hourly rate by the employee;

(2) the employee's address, telephone number, date of first day of work;

(3) records sufficient to establish compliance with the Employer Spending Requirements of this Ordinance, including, as applicable, records of health care expenditures made, calculations of health care expenditures required under this Ordinance for each covered employee, and proof documenting that such expenditures were made at least quarterly each year; and, if applicable,

(4) a signed Employee Voluntary Waiver Form (see Appendix A) for every employee for whom a covered employer seeks to claim an exemption from the Employer Spending Requirement; and

(5) a copy of the Employer Notice to Employee of Payment to the City (see Appendix B).

(B) Employers meeting the requirements of the limited exception outlined in Regulation 6.2(8)(2) shall not be required to demonstrate that expenditures under such plans were made quarterly.

(C) All records necessary to establish compliance with the Employer Spending Requirements of this Ordinance shall be made accessible by covered employers to the OLSE.

(D) Where an employer does not maintain or retain adequate records documenting the health care expenditures made, or does not allow the OLSE reasonable access to such records, it shall be presumed that the employer did not make the required health care expenditures for the quarter for which records are lacking. This presumption shall be rebutted only by clear and convincing evidence.

7.3 Employer Reporting

Covered employers shall provide information to the City regarding its health care expenditures on an annual basis. Such information shall be provided on the HCSO Mandatory Annual Reporting Form, which shall be mailed to all registered businesses and returned with the employer's annual business registration submission to the City, as mandated by Article 12 of the Business and Tax Regulations Code. Additional copies of the HCSO Mandatory Annual Reporting Form may be obtained from the OLSE.

7.4 Employer Cooperation with OLSE Investigation & Enforcement

All covered employers shall cooperate fully with the OLSE in connection with any investigation of an alleged violation of this Ordinance or with any audit or inspection conducted by the OLSE.

7.5 Prohibition against Actions or Attempts to Avoid Employer Coverage

(A) It is unlawful for any employer to reduce the number of employees in order to:

(1) avoid being considered a covered employer, or to

(2) be subject to a lower health care expenditure rate.

(B) In the event of an investigation on a claim based on Section 14.4(c) of the Ordinance, the employer shall be required to demonstrate that such reduction in staffing was for a valid business reason.

7.6 Prohibition against Retaliation

(A) It shall be unlawful for any employer to deprive or threaten to deprive any person of employment, take or threaten to take any reprisal or retaliatory action against any person, or directly or indirectly intimidate, threaten, coerce, command or influence or attempt to intimidate, threaten, coerce, command or influence any person because such person has cooperated or otherwise participated in an action to enforce, inquire about, or inform others about the requirements of this Ordinance.

(B) Taking adverse action against a person within ninety (90) days of the person's exercise of rights protected under this Ordinance shall raise a rebuttable

presumption of having done so in retaliation for the exercise of such rights.

7.7 Prohibition against Discrimination

It shall be unlawful for any employer to refuse to hire, employ, or select for a training program leading to employment; to discharge from employment or from a training program leading to employment; or to discriminate against a person in compensation or in terms, conditions, or privileges of employment, based on whether s/he possesses health insurance coverage.

REGULATION 8: OLSE ENFORCEMENT

8.1 OLSE Investigation & Enforcement

(A) The OLSE has the authority to conduct investigation and monitoring and to seek, for violations of this Ordinance, all of the penalties imposed by this Ordinance in order to further its purposes. The Labor Standards Enforcement Officer and other City employees and agents or designees authorized to assist in the administration and enforcement of the requirements of this Ordinance shall have the right to engage in random inspections of employment sites; to have access to workers and other witnesses; and to conduct audits of employer records as reasonably deemed necessary to determine compliance with this Ordinance, including, but not limited to, employee time sheets, payroll records, employee paychecks, and other documents described in Regulation 7.2.

(B) Where prompt compliance is not forthcoming, the OLSE may take any appropriate enforcement action to secure compliance, including initiating a civil action, and/or, except where prohibited by state or federal law, requesting that City agencies or departments revoke or suspend any registration certificates, permits, or licenses held or requested by the em-

ployer or person until such time as the violation is remedied.

8.2 Administrative Complaint Procedure

(A) The OLSE shall have sole authority over the administration of the following complaint procedure. This procedure shall include, but need not be limited to, the following:

(1) Any person may file a complaint alleging one or more violations of this Ordinance;

(2) Before beginning to investigate the complaint, the Labor Standards Enforcement Officer shall determine if the allegations of the complaint are sufficient and, based on that assessment, shall determine either to dismiss it or to proceed with an investigation;

(3) If the Labor Standards Enforcement Officer determines at any time that the allegations contained in the complaint are without merit, the Labor Standards Enforcement Officer shall notify the complainant; and

(4) If the Labor Standards Enforcement Officer finds that any allegations in the complaint have merit, the Labor Standards Enforcement Officer shall investigate the matter.

(B) This complaint procedure shall not preclude the Labor Standards Enforcement Officer from initiating or proceeding with an investigation on his or her own authority.

8.3 Notice of Violation

(A) If the OLSE determines that an employer may have violated or is not in compliance with this Ordinance, the OLSE shall issue written notification to the

employer mandating compliance within no fewer than ten (10) calendar days from the date of the notification.

(B) The OLSE may, at its discretion, allow the employer additional time beyond the ten (10) calendar days to make the corrections should the OLSE determine that the employer is making a good faith effort to comply.

(C) If, after ten (10) days of the Notice of Violation to the employer by the OLSE, the violation or failure to comply continues and no resolution is imminent, the OLSE may issue a Determination of Violation.

8.4 Determination of Violation

(A) The Determination of Violation shall include:

(1) a description of the violation;

(2) a citation of the provisions of the law violated;

(3) a description of the corrective action required and a timeline within which the action(s) must be completed;

(4) the amount of administrative penalty imposed for the violation(s) and a timeline for payment of such penalty, if applicable;

(5) a description of the process for appealing the Determination of Violation, including the deadline for filing such an appeal; and

(6) the name and signature of the Director of the OLSE or his/her designee.

8.5 Service

(A) Service of a Notice of Violation or Determination of Violation may be accomplished as follows:

(1) The OLSE may obtain the signature of the employer or a representative of the employer responsible for the violation to establish personal service of the document; or

(2) The OLSE may post the document by affixing the document to a surface in a conspicuous place on the employer's place of business or the fixed location within the City from or at which the employer conducts business in the City; or

(3) The OLSE may serve the document by first class mail as follows:

(a) The document shall be mailed to the employer by first class mail, postage prepaid, with a declaration of service under penalty of perjury; and

(b) A declaration of service shall be made by the person mailing the document, show the date and manner of service by mail, and recite the name and address of the employer to whom the Notice of Violation or Determination of Violation is issued.

Service of the document by mail in the manner described above shall be effective on the date of the mailing.

REGULATION 9: CORRECTIVE ACTION AND ADMINISTRATIVE PENALTIES

9.1 Corrective Action

The OLSE may order employers who violate this Ordinance to take appropriate corrective action to address violations of this Ordinance. The OLSE shall not be limited to ordering the actions described below, but may order any other actions it deems necessary to correct the violation(s) committed. Where the OLSE has reason to believe that a violation has occurred, it may order any appropriate temporary or

interim relief to mitigate the violation or maintain the status quo, pending completion of a full investigation or hearing.

9.2 Administrative Penalties

(A) If corrective action is not taken, the OLSE may impose administrative penalties upon employers who violate this Ordinance, including, but not limited to, the violations described below. All penalties may be assessed by means of a Determination of Violation issued by the Director of the OLSE or his/her designee.

VIOLATION	CORRECTIVE ACTION	ADMINISTRATIVE PENALTY
Failure to make the required health care expenditures (Admin. Code §§ 14.3(a) & 14.4(c)):	The party shall be ordered to make the required health care expenditure on behalf of each employee or person whose rights under this Ordinance was violated, and/or to reimburse the individual for any and all out-of-pocket medical expenses incurred by that individual for the period during which the employer was in violation of this Ordinance, up to	The penalty assessed shall be up to one-and one-half times the total expenditures that a covered employer failed to make, plus interest of up to ten (10) percent on all due and unpaid health care expenditures, from the date payment should have been made. The total penalty for this violation shall not exceed $1,000 for each employee for each week that such expenditures were or are not made.

	the amount of the required health care expenditure. This payment shall be made retroactively, from the date the expenditure was due, and continuing until the case is resolved to the satisfaction of the OLSE.	
Failure to cooperate with the OLSE or otherwise impeding the OLSE's ability to conduct an audit or investigation (Admin. Code §§ 14.3(b) & 14.4(e)):	The party shall be ordered to cooperate with the OLSE, effective immediately.	The penalty assessed shall be $25 per day for each day that the violation occurred or occurs.
Failure to allow reasonable access to records of health care expenditures (Admin. Code §§ 14.3(b) & 14.4(e)):	The party shall be ordered to provide the OLSE with reasonable access to records of health care expenditures.	The penalty assessed shall be $25 for each worker whose records are at issue for each day that the violation occurred or occurs.

Failure to maintain or retain accurate and complete records, including destruction of relevant evidence (Admin. Code §§ 14.3 (b) & 14.4(e); Regulation 7.2):	The party shall be ordered to produce the records and documents outlined in Regulation 7.2 and to cooperate with the OLSE in reconstructing the records it should have maintained	The penalty assessed shall be $500.
Failure to satisfy the annual reporting requirement (Admin. Code §§ 14.3(b) and 14.4(e)):	The party shall be ordered to satisfy its annual reporting requirement.	The penalty assessed shall be $500
Reduction of the number of employees in order to (1) avoid being considered a covered employer, or to (2) be subject to a lower health care expenditure rate (Admin. Code §§ 14.4(c); Regulation 7.5):	The party shall demonstrate that such reduction was not done for the purpose of evading the obligations of this Ordinance, but for a valid business reason, or shall be in violation of this Ordinance. If unable to do so, the party shall be ordered to make the required	The penalty assessed shall be $25 per day for each day that the violation occurred or occurs.

	health care expenditure on behalf of each employee or person whose rights under this Ordinance was violated, and/or to reimburse the individual for any and all out-of-pocket medical expenses incurred by that individual for the period during which the employer was in violation of this Ordinance, up to the amount of the required health care expenditure. This payment shall be made retroactively, from the date the expenditure was due, and continuing until the case is resolved to the satisfaction of the OLSE.	

Retaliation, including harassment, and/or discrimination in violation of the Ordinance (Admin. Code §§ 14.4(d); Regulations 7.6-7.7):	The party shall be ordered to cease, or cause to cease, any and all retaliatory and/or discriminatory actions, and if applicable, to reinstate or otherwise compensate an employee whose rights under this Ordinance.	The penalty assessed shall be $100 for each worker or person whose rights under this Ordinance was violated for each day that the violation occurred or occurs.

(B) Payment of the penalty shall not excuse the failure to correct the violation, nor shall it bar any further enforcement action by the OLSE.

(C) If penalties and/or costs are the subject of administrative appeal or judicial review, then the accrual of such penalties and/or costs shall be stayed until the determination of such appeal or review is final.

9.3 Payment of Penalties and Interest

(A) All administrative penalties shall be made payable to the City and County of San Francisco, be due within thirty (30) days from the date of the Determination of Violation, and be deposited in the City's General Fund when collected.

(B) All interest owing on unpaid health care expenditures shall be made payable to the employee on whose behalf the expenditures should have been made and be due within thirty (30) days from the date of the Determination of Violation.

9.4 Collection of Penalties; Civil Enforcement

(A) The failure of any employer to pay a penalty assessed by Determination of Violation within the time specified on the Determination of Violation constitutes a debt to the City.

(B) The City Attorney may bring a civil action or pursue any other legal remedy to recover civil penalties for the violations set forth in subsections 14.4 (e)(1842) of this Ordinance in the same amounts set forth in those subsections, and to recover the City's enforcements costs, including attorneys' fees. Enforcement costs shall not count toward any maximum penalty amount set forth in these regulations.

(C) The City may create and impose liens against any property owned or operated by an employer who fails to pay a penalty assessed by the Determination of Violation. The procedures provided for in Article XX of Chapter 10 of the San Francisco Administrative Code shall govern the imposition and collection of such liens.

REGULATION 10: ADMINISTRATIVE APPEALS

10.1 Administrative Appeals

(A) Persons receiving a Determination of Violation may appeal it within fifteen (15) days from the date the document is served. The appeal must:

(1) be in writing and specify the basis for the appeal in detail,

(2) indicate a return address,

(3) be accompanied by the penalty amount,

(4) be filed with the Controller's Office, and

(5) be filed with a copy to the OLSE.

The failure of any person to file an appeal in accordance with the provisions of this Section shall constitute concession to the assessment, and the Determination of Violation shall be deemed final upon expiration of the 15-day period.

(B) Within fifteen (15) days of receiving a proper request for appeal, the Controller or his or her designee shall appoint a hearing officer (who shall not be employed in the Office of Labor Standards Enforcement) to hear and decide the administrative appeal and shall so advise the OLSE and the appellant.

(C) The hearing officer shall promptly set a date, time and place for a hearing on the appeal. Written notice of the time and place for the hearing may be served by first class mail.

(1) Service of the notice must be made at least ten (10) days prior to the date of the hearing to the appellant.

(2) The failure of any person to appear at the hearing shall constitute concession to the assessment,

(3) Except as otherwise provided by law, the failure to receive a properly addressed notice of the hearing shall not affect the validity of any proceedings under this Ordinance.

(D) The hearing must commence no later than thirty (30) days after service of notice of the hearing and conclude within seventy-five (75) days of such notification, unless that time is extended by mutual agreement of all parties.

(E) No later than five (5) days prior to the hearing, the appellant and the OLSE shall submit to the hearing officer, with simultaneous service on the op-

posing party, written information including, but not limited to, the following: the statement of issues to be determined by the hearing officer and a statement of the evidence to be offered and the witnesses to be presented at the hearing.

(F) The hearing officer appointed by the Controller or the Controller's designee shall conduct all appeal hearings under this Ordinance. The hearing officer may accept evidence on which persons would commonly rely in the conduct of their serious business affairs, including, but not limited to, the following:

(1) A valid Determination of Violation shall be prima facie evidence of the violation;

(2) The hearing officer may accept testimony relating to the violation and/or to the appropriate means of correcting the violation by declaration under penalty of perjury;

(3) The person responsible for the violation, or any other interested person, may present testimony or other evidence concerning the violation and the means and time frame for correction.

10.2 Burden of Proof

The appellant shall have the burden of proving that the basis for the Determination of Violation is incorrect.

10.3 Hearing

(A) Hearing Record. The hearing shall be open to the public and shall be tape-recorded. Any party to the hearing may, at his or her own expense, cause the hearing to be recorded and transcribed by a certified court reporter. The hearing officer may continue the hearing and request additional information from either party prior to issuing a written decision.

(B) Findings and Decision. The hearing officer shall make findings based on the record of the hearing and issue a written decision based on such findings within fifteen (15) days of conclusion of the hearing. The hearing officer's decision may:

(1) uphold the issuance of a Determination of Violation and penalties stated therein,

(2) dismiss a Determination of Violation, or

(3) uphold the issuance of the Determination of Violation but reduce, waive or conditionally reduce or waive the penalties stated in a Determination of Violation or any late fees assessed if mitigating circumstances are shown and the hearing of officer finds specific grounds for reduction or waiver in the evidence presented at the hearing.

The hearing officer may impose conditions and deadlines for the correction of violations or the payment of outstanding civil penalties.

(C) Finality of Hearing Officer's Decision. The decision of the hearing officer shall be final. If the hearing officer concludes that the violation(s) charged did not occur or that the person charged in the Determination of Violation was not the responsible party, the OLSE shall refund or cause to be refunded the penalty amount to the party that deposited such amount. The hearing officer's decision shall be served on the appellant and the OLSE by certified mail.

(D) Writ of Mandate. The sole means of review of the hearing officer's decision shall be made by filing in the San Francisco Superior Court a petition for a writ of mandate under Section 1094.5 of the California Code of Civil Procedure.

(17)

No. 08-1515

Supreme Court, U.S.
FILED
AUG 24 2009
OFFICE OF THE CLERK

In The Supreme Court of the United States

GOLDEN GATE RESTAURANT ASSOCIATION,

Petitioner,

v.

CITY AND COUNTY OF SAN FRANCISCO,

Respondent,

SAN FRANCISCO CENTRAL LABOR COUNCIL; SERVICE EMPLOYEES INTERNATIONAL UNION ("SEIU"), LOCAL 1021; SEIU UNITED HEALTHCARE WORKERS-WEST; and UNITE HERE! LOCAL 2,

Intervenors/Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

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QUESTION PRESENTED

San Francisco's universal health care ordinance contains two interlocking components: a comprehensive public health care program available to all uninsured residents at sliding scale fees, and a general health care spending requirement for medium and large employers. Employers may comply with the spending requirement either through their own health care plans, or by paying into the public program. If employers choose the public option, their employees receive a substantial discount on the health care services available through that program. The question presented is:

Does ERISA preempt the portion of San Francisco's universal health care ordinance that imposes a general health care expenditure requirement on medium and large employers, where every employer may readily comply without adopting an ERISA plan or altering an existing plan, and where the option of paying into the public program is a rational choice for employers rather than a penalty?

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STATEMENT

A. The Health Care Security Ordinance

In 2006, San Francisco was in the midst of a health care crisis. An estimated 82,000 people were without coverage. *See* Resp. App. 11. Tens of thousands more only had coverage under bare-bones "safety-net" programs, such as Medicaid, that provided limited care to indigent residents. *Id.* Not only did this threaten the health and well-being of many San Francisco residents; it put tremendous strain on the taxpayers, who were forced to bear the cost when the uninsured used public hospital emergency rooms for preventable illness or injury. *Id.* at 28.

To address this crisis, San Francisco's Board of Supervisors enacted the Health Care Security Ordinance ("HCSO" or "ordinance"). The ordinance has two interlocking components – a public health care program, and an employer health care spending requirement.

The public program is operated by the City's Department of Public Health ("DPH"). Its primary feature is the Health Access Program ("HAP"), which delivers health care to participants from a network of public and private providers. Pet. App. 113a (S.F., Cal., Admin. Code § 14.2(a) (2007)).[1] The HAP assigns

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[1] The City has changed the name of the program from the HAP to "Healthy San Francisco." For purposes of litigation, the parties have continued to use the name contained in the ordinance.

a primary care physician, nurse practitioner or physician assistant to each participant. Among the specific services provided are preventive care, inpatient and outpatient hospital services, diagnostic and laboratory services, radiological services, mental health services, home health care, and prescription drug benefits. Pet. App. 114a (Admin. Code § 14.2(f)). The value of this care is substantial – DPH estimated that in 2008 it cost the City an average of $261 per participant per month to provide. Resp. App. 13.

The HAP is funded primarily by City tax dollars and partly by employer payments. It is available to uninsured San Francisco residents, regardless of whether they are employed. Enrollees must pay quarterly participation fees on a sliding scale, and must make co-payments for medical visits.

The other component of the ordinance is a mandate that medium and large businesses make minimum health expenditures on behalf of employees who work more than a specified number of hours. Specifically, in 2009, private employers with 20-99 employees, and nonprofit employers with 50 or more employees, must spend $1.23 per hour on behalf of any employee who has been employed for 90 days and works more than eight hours per week. Private employers with 100 or more employees must spend $1.85 per hour for each such employee. The requirement is capped at 40 hours per week. Pet. App. 111a-12a (Admin. Code § 14.1(b)(8), (10); Pet.

App. 138a (S.F., Cal., Office of Labor Standards Enforcement Reg. 5.2(A)(1)).

According to studies compiled by the San Francisco Controller's Office, roughly 90% of medium and large businesses already provided health insurance to their employees when the ordinance was enacted. Resp. App. 15. And the average monthly insurance premium in California at that time was $379. *Id.*

To comply with the mandate, employers may spend money through their own health care plans, or make payments to the City on behalf of their workers. *Id.* They may also fulfill the expenditure obligation through a combination of methods. For example, an employer may prefer to keep its full-time employees in a private ERISA plan while selecting the public option for its part-time employees.

The program is structured so that, if an employer chooses the city payment option, it need only write a check, and all employees on whose behalf payment is made are eligible to participate in the City's program. Contrary to petitioner's representation, the employer does not "enroll [its] employees with the City." Pet. 10. The employer simply pays the City on behalf of specified workers, and notifies the workers that it has done so. Pet. App. 144a (OLSE Reg. 7.2(A)(5)). The rest (enrollment, the type of care provided,

copayments) is purely between the City and the individual.[2]

Employees who qualify for HAP membership are, if their employers choose to satisfy the spending requirement by paying the City, entitled to enroll in the program at a 75% discount on the quarterly participation fees they would otherwise be required to pay. Resp. App. 53-54 (DPH Reg. 7(f)). As discussed more fully below, the result is that, when an employer pays the City, the employer knows its workers will be eligible for comprehensive care at a far lower cost than what it would have to pay for private insurance.

The City also adopted two regulatory provisions – unmentioned by petitioner – that facilitate compliance for large, multijurisdictional employers. The first may be utilized by employers that provide traditional health insurance to their workers, such as Kaiser or Blue Shield. It allows these employers to establish compliance without keeping track of the health care dollars spent on each individual employee, and without making any separate calculations for their San Francisco employees. Pet. App. 141a (OLSE Reg. 6.2(B)(1)). An employer that purchases

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[2] Individuals who work in San Francisco but live elsewhere do not qualify for HAP participation, but the City uses employer payments to provide medical reimbursement accounts for such individuals. They may draw from their accounts to obtain reimbursement for medical expenses, including payments of health insurance premiums. Pet. App. 110a, 114a-15a (Admin. Code §§ 14.1(b)(7), 14.2(g)); Resp. App. 55 (DPH Reg. 7(g)(i)).

insurance for its employees in San Francisco and in other parts of the country need only divide its total payments to the insurance company for all those employees by the total number of employees. Assuming the amount per employee is greater than the spending obligation (and private health insurance is far more expensive than the spending obligation), this establishes compliance.

The second regulatory provision allows employers that operate "self-insured" plans (through which the employer bears the risk of employee health care costs on its own rather than paying an insurance company a set rate to bear that risk) to establish compliance in similar fashion. It provides that such employers comply "if the preceding year's average expenditure rate per employee meets or exceeds the applicable expenditure rate . . . for that employer." Pet. App. 141a (OLSE Reg. 6.2(B)(2)). Accordingly, an employer with a self-insured plan may establish compliance simply by showing that it has spent a certain amount per employee on a plan-wide basis.

The medium and large employers subject to the ordinance must also keep records. These records are generally already kept in the normal course of business, and employers are not "required to maintain such records in any particular form." Pet. App. 116a. Once per year, employers must file a one-page report with the City, identifying the total amount paid for health care and the manner in which the money was spent. Pet. App. 144a (OLSE Reg. 7.3).

Since the HCSO became fully operational in January 2008, San Francisco has taken great strides towards the achievement of universal health care. In less than 1½ years, the number of residents without health coverage dropped from 82,000 to fewer than 23,000, and that number continues to go down. Resp. App. 25. Following enactment of the ordinance, emergency room visits at San Francisco General Hospital dropped almost seventy percent in one year – from 29,976 to 8,944. *Id.* at 28.

B. Procedural History

Petitioner filed suit in the Northern District of California, alleging that the Employee Retirement Income Security Act of 1974 ("ERISA") preempts the health care spending requirement. The district court granted summary judgment for petitioner, reasoning that the ordinance was "designed to act immediately upon, and cannot operate successfully without the existence of [ERISA] plans." Pet. App. 93a. At the same time, however, the court rejected petitioner's contention that monetary payments by employers to the City themselves create a "*de facto* ERISA plan." Pet. App. 94a.

The Ninth Circuit granted the City's application for a stay of the district court's ruling. The court ruled that, given the availability of a non-ERISA compliance option for every type of employer (namely, payment to the City), the district court was wrong to conclude that the ordinance acts immediately upon

ERISA plans or interferes with plan uniformity. *Golden Gate Rest. Ass'n v. City & County of San Francisco*, 512 F.3d 1112, 1119-23 (9th Cir. 2008). The court noted that legal requirements like San Francisco's – that "only relate[ ] to ERISA plans at the election of an employer" – are regularly upheld against ERISA preemption challenges. *Id.* at 1122 (quotations omitted). The court also concluded that the balance of hardships tipped in favor of the City, and that the public interest weighed in favor of a stay pending appeal. *Id.* Petitioner filed an application to this Court to lift the Ninth Circuit's stay order, which was denied by the Circuit Justice.

After the parties briefed and argued the case on the merits, the Ninth Circuit reversed the district court. This time, petitioner and its allies focused on the argument that an employer actually creates an ERISA plan when it writes a check to the City, thereby leaving employers with no non-ERISA means for complying with San Francisco's requirement. The Ninth Circuit rejected this argument, determining that the city payment option lacks most *indicia* of an ERISA plan. The court observed that the employer's obligations under the city payment option "do not run the risk of mismanagement of funds or other abuse," which was the original concern that led to ERISA's passage. Pet. App. 20a. It observed that the HAP is a government entitlement program, funded primarily by taxpayer dollars, that is available to residents regardless of employment status. Pet. App. 24a-25a. And the court described the key differences between

the city payment option and an employer's purchase of health insurance from a third party, which does involve the creation of an ERISA plan. *Id.* at 26a.

Petitioner also persisted in the argument that, even if payments to the City do not create an ERISA plan, the spending requirement was preempted because it had an improper "connection with" ERISA plans. The court rejected this argument, explaining that the existence of the city payment option meant no employer was required to adopt an ERISA plan, or to provide specific benefits through an existing ERISA plan. Pet. App. 29a. The court also rejected the argument that the HCSO has a forbidden "reference" to ERISA plans, observing that "[w]here a law is fully functional even in the absence of a single ERISA plan . . . as it is in this case, it does not make an impermissible reference to ERISA plans." Pet. App. 36a.

Petitioner sought en banc rehearing, which was denied. Petitioner then filed an application to this Court for a stay pending a petition for certiorari, which was also denied.

ARGUMENT

The Court of Appeals correctly upheld San Francisco's program, because ERISA does not preempt local requirements that give employers a reasonable option for complying that does not involve the adoption or alteration of an ERISA plan. The

option to pay the City is a reasonable choice for employers, and it does not create an ERISA plan.

The city payment option is reasonable, indeed attractive, because the employers' payments make their workers eligible for comprehensive health services, funded primarily by City tax dollars, for far less than the employers would have to pay for comparable benefits on the private market. As such, this case is clearly distinguishable from *Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180 (4th Cir. 2007), which struck down a Maryland law that imposed a bare penalty on Wal-Mart for failing to provide an adequate ERISA plan for its employees.

Nor does the employer create an ERISA plan by exercising the city payment option. This arrangement neither meets the statutory definition of such a plan nor implicates ERISA's central concern – ensuring that benefits promises by private employers to their employees are kept. As the Ninth Circuit explained in detail, writing a check to the City on behalf of specified employees is not remotely analogous to third-party health insurance contracts, which *are* ERISA plans.

At the end of the day, petitioner's argument rests on a faulty premise: that ERISA immunizes employers from being required to spend money in areas, like health care, mentioned in the ERISA statute. As this Court has already explained, ERISA preemption protects only plan uniformity for employers, not general expenditure uniformity.

Because the ordinance in no way interferes with plan uniformity, the Ninth Circuit's ruling that it is not preempted is consistent with this Court's ERISA preemption jurisprudence.

This case is the wrong vehicle, at the wrong time, to consider an employer's claim that ERISA preempts general health care spending requirements. Petitioner presented no evidence that the city payment option is not a rational choice for employers. Nor did it present evidence that the ordinance, even if replicated elsewhere, would impose anything but a *de minimis* administrative obligation on employers. Indeed, the only evidence in the record on these issues contradicts petitioner's claims.

Nor is there any immediate threat that numerous similar laws will sprout up throughout the country, particularly with Congress considering federal health care reform legislation. And the serious possibility that federal legislation will moot the ERISA preemption issue in this case weighs heavily against the Court granting certiorari now. Finally, if federal legislation is not enacted, and if other jurisdictions were then to enact laws similar to San Francisco's in the future, this Court would have the opportunity to address the arguments presented by petitioner and its allies at that time, and on a better record.

I. THERE IS NO CONFLICT WITH THE FOURTH CIRCUIT.

There is widespread agreement that ERISA does not preempt a local requirement if employers have a reasonable non-ERISA means to comply with that requirement. *See, e.g., Keystone Chapter, Associated Builders & Contractors v. Foley*, 37 F.3d 945, 960 (3d Cir. 1994) ("[w]here a legal requirement may be easily satisfied through means unconnected to ERISA plans, and only relates to ERISA plans at the election of an employer, it affects employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan") (internal quotations, citations and brackets omitted). *See also Fielder*, 475 F.3d at 193 (state laws that "do not bind the choices of employers or their ERISA plans [are] generally not preempted"); *WSB Elec., Inc. v. Curry*, 88 F.3d 788, 795 (9th Cir. 1996) ("nothing in California's scheme requires the establishment of a separate benefit plan in order to comply with the state law. California's statute does not require public works contractors to modify their benefits plans at all").

The above rule is grounded firmly in this Court's precedents, which make clear that while ERISA preempts laws that dictate employer choices about employee welfare benefit plans, it does not preempt generally applicable laws that merely influence choices with respect to ERISA plans. Thus, ERISA prevents states from dictating *which benefits* must be contained in plans. *See, e.g., Shaw v. Delta Air Lines,*

Inc., 463 U.S. 85, 96-97 (1983) (striking down law that required plans to include pregnancy benefits). It prevents states from forcing employers to *adopt* ERISA plans in the first place. *See, e.g.*, *Standard Oil v. Agsalud*, 633 F.2d 760, 766 (9th Cir. 1980), *summarily aff'd*, 454 U.S. 801 (1981) (striking down Hawaii law that required employers to adopt ERISA plans with specified benefits). And it prevents states from dictating *who* must benefit from ERISA plans. *Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2001) (state law preempted because it "binds ERISA plan administrators to a particular choice of rules for determining beneficiary status").

In contrast, ERISA does not preempt health care surcharges that exert a strong influence on decisions about ERISA plans. *See N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 659-60 (1995). It does not preempt imposition of a generally applicable tax upon facilities owned by ERISA plans. *De Buono v. NYSA-ILA Med. & Clinical Services Fund*, 520 U.S. 806, 816 & n.16 (1997). And it does not preempt state laws that give powerful incentive to ERISA apprenticeship programs to seek regulatory approval from the state, and to make the changes necessary to obtain such approval, as long as the laws do not force them to do so. *Cal. Div. of Labor Stds. Enforcement v. Dillingham Constr., N.A.*, 519 U.S. 316, 332-33 (1997).

Obviously, if employers may readily comply with a requirement without adopting or altering ERISA plans, such a requirement does not dictate choices

with respect to plans. As set forth below, the Fourth and Ninth Circuits merely applied this well-established principle in the specific context of health care spending, and reached consistent results.

Fielder involved a preemption challenge to Maryland's Fair Share Act, which provided that any Maryland for-profit employer with more than 10,000 employees that does not spend up to 8% of its payroll on health insurance (*i.e.*, Wal-Mart) must make up the deficiency by paying it to the Maryland Secretary of Labor. 475 F.3d at 184. Wal-Mart's employees would not receive any benefits, services, or cost savings in return for such payments. *Id.* at 193.

The Fourth Circuit held that this law effectively required Wal-Mart to alter its ERISA plan because no rational employer would choose to pay the money to the State when the employer could instead increase health care spending in a manner that benefited its employees:

> An employer would gain from increasing the compensation it offers employees through improved retention and performance of present employees and ability to attract more and better new employees. In contrast, an employer would gain nothing in consideration of paying a greater sum of money to the State. Indeed, it might suffer from lower employee morale and increased public condemnation.

> In effect, the only rational choice employers have under the Fair Share Act is to *structure their ERISA healthcare benefit plans* so as to meet the minimum spending threshold. The Act thus falls squarely under *Shaw*'s prohibition of state mandates on *how employers structure their ERISA plans*.

Id. at 193-94 (emphasis added).

As the Ninth Circuit explained, San Francisco's ordinance, "[i]n stark contrast to the Maryland law, . . . offers employers a meaningful alternative that allows them to preserve the existing structure of their ERISA plans." Pet. App. 38a-39a. Workers whose employers comply through payments to the City, rather than by establishing or altering ERISA plans, receive "tangible benefits" in return. *Id.*

Highlighting the reasonableness of the city payment option, almost nine hundred medium and large businesses selected it in the first 1½ years of its existence. Resp. App. 33. That so many employers have selected this option is not surprising, since it allows employers to avoid the inconvenience of setting up their own ERISA plans, while knowing that their workers will receive comprehensive health

coverage from the City at a price far lower than it would cost the employers in the private market.[3]

In short, the option to pay the government in *Fielder* was a penalty that no rational employer would choose. The city payment option here is not a penalty, because it gives employers a meaningful, non-ERISA compliance alternative that allows them to maintain plan uniformity. San Francisco's ordinance, in other words, is utterly indifferent to whether an employer has an ERISA plan. Thus, under the Fourth Circuit's analysis, an ordinance like San Francisco's would survive a preemption challenge. While the Fourth Circuit concluded that Maryland's law "directly regulat[ed] the structuring or administration of an ERISA plan," 475 F.3d at 192, it could not have made the same statement about the HCSO. The two decisions operate in harmony, and they are both consistent with established ERISA precedent from other contexts.

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[3] The City presented unrebutted evidence in the district court that the health benefits received by employees from the City are extraordinarily generous in relation to the amount paid by the employer, and in comparison to the amount the employer would be required to pay on the private market. The average insurance premium in California was $379 per month when the ordinance took effect. In contrast, for a medium-sized employer with an employee who works 20 hours per week, the employer could satisfy its spending obligation in 2008 by paying the City $ 93.60 per month, even though it would cost the City much more than that to provide the care. In short, the city payment option gives employees a HAP membership that provides comprehensive health services at pennies on the dollar for the employer.

Notwithstanding this, petitioner claims a circuit conflict based on the Fourth Circuit's discussion of an issue that was not presented to, or considered by, the Ninth Circuit. Specifically, after holding that the option of paying the government was nothing more than a penalty that forced Wal-Mart to alter its ERISA plan, the Fourth Circuit turned to Maryland's alternative argument that Wal-Mart had other, private non-ERISA alternatives for complying. According to Maryland, Wal-Mart could satisfy the spending requirement through the creation of on-site medical clinics or Health Savings Accounts. The court rejected this argument on the ground that the purported alternatives were unrealistic. 475 F.3d at 196. And *then* the court observed that even if Wal-Mart could avail itself of these options, they would necessarily also produce a change in the company's ERISA plan:

> If Wal-Mart were to attempt to utilize non-ERISA health spending options to satisfy the Fair Share Act, it would need to coordinate those spending efforts with its existing ERISA plans. For example, an individual would be eligible to establish a Health Savings Account only if he is enrolled in a high deductible [ERISA] health plan. *See* 29 U.S.C. § 223(c)(1). In order for Wal-Mart to make widespread contributions to Health Savings Accounts, it would have to alter its package of ERISA health insurance plans to encourage its employees to enroll in one of its high deductible health plans. From the employer's perspective, the categories of ERISA and non-ERISA healthcare spending

> would not be isolated, unrelated costs. Decisions regarding one would affect the other and thereby violate ERISA's pre-emption provision.

Id. at 196-97. This is not, as petitioner asserts, an alternative holding by the Fourth Circuit that *any* spending mandate in the health care area must be preempted – *i.e.*, that every conceivable non-ERISA compliance option would become entangled with ERISA plans and necessarily interfere with ERISA plan uniformity. It is a rejection of the specific arguments presented by Maryland.[4]

Finally, the implications of a rule preventing local governments from imposing any general health care spending requirement on employers show that the Fourth Circuit could not have intended to adopt such a rule. San Francisco's ordinance goes out of its way to avoid giving employers an incentive to adopt or alter ERISA plans. If, instead, San Francisco imposed a payroll tax on employers to fund a comprehensive public health care program *without regard* to whether employers already have health care plans (that is, without giving employers credit for the health care spending they already make), this

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[4] Petitioner omits the sentences from the above passage which show that the Fourth Circuit was addressing Maryland's specific argument about the non-ERISA compliance options it offered. As Judge William Fletcher pointed out in his opinion concurring in the denial of rehearing en banc, the eight dissenting judges from the Ninth Circuit did the same thing. Pet. App. 45a-46a.

would create a significant incentive for employers to drop their ERISA plans, to avoid spending substantial sums on health coverage that their employees could instead obtain for free. Nobody could reasonably argue that such a payroll tax would be preempted. It would be ironic, then, if ERISA were held to preempt a law that imposed far fewer incentives with regard to plans. Given the backwards legal regime that would result from the broad rule that petitioner ascribes to *Fielder*, there is no basis for concluding that the Fourth Circuit intended to adopt it.[5]

II. THERE IS NO CIRCUIT CONFLICT ON WHETHER PAYMENTS TO THE CITY INVOLVE THE CREATION OF AN ERISA PLAN.

Petitioner and some *amici* also argue that the Ninth Circuit created a conflict by rejecting the argument that when an employer opts to comply with the HCSO by writing a check to the City, this itself

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[5] As discussed by the Brief of *Amicus Curiae* Nibbi Bros. Associates, Inc., courts have reached the same conclusion about the many prevailing wage laws that allow employers to comply in part by providing ERISA benefits to their employees. If ERISA preempted prevailing wage laws that gave employers credit for ERISA spending, while leaving undisturbed prevailing wage laws that refused to give credit for ERISA spending, this would incent employers to drop ERISA plans, which is precisely the opposite of what the preemption provision intended. Petitioners seek a result that would disturb the settled understanding among the circuits that prevailing wage laws with benefits components are not preempted.

involves the creation of an ERISA plan. But no other appellate decision even considers whether a public payment option is an ERISA plan. Accordingly, to create the illusion of a conflict, petitioner and its allies rely on cases which hold that an employer creates an ERISA plan when it contracts with a health insurance company to provide health care to its workers. *See, e.g.*, *Brundage-Peterson v. Compcare Health Servs. Ins. Corp.*, 877 F.2d 509, 511 (7th Cir. 1989). They attempt to analogize these insurance contracts to the city payment option, and contend a circuit conflict exists because the Ninth Circuit rejected the analogy. That is not a real conflict. And the Ninth Circuit was right to reject the analogy, which is inapt, is contrary to the purposes of ERISA, and would, if adopted, create serious problems in ERISA preemption law.

ERISA defines an "employee welfare benefit plan" as "any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer . . . for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise," specified benefits. 29 U.S.C. § 1002(1). The specified benefits include, among others, vacation, disability, unemployment, severance, and, of course, medical benefits. *Id.*

In *Massachusetts v. Morash*, 490 U.S. 107 (1989), this Court explained that because the reach of the above definition of an employee welfare benefit plan is – like the preemption provision – potentially limitless, the determination whether a particular

arrangement is the type of "plan" that falls within ERISA's ambit must be made with reference to "'the provisions of the whole law, and to its object and policy.'" *Id.* at 115 (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 51 (1987)). Applying this principle, the Court in *Morash* determined that vacation benefits paid out of general assets did not present the types of risks that Congress intended to address when it enacted ERISA and, therefore, that it would not read the statute to encompass such an employer policy to pay vacation benefits. *Id.*

Here, an examination of ERISA's "object and policy" demonstrates why the Ninth Circuit was right to reject petitioner's analogy to an insurance contract. While petitioner and its *amici* paint ERISA as a law whose central purpose is to preserve some undefined "uniformity" for employers, in actuality the statute's "primary concern" is "with the mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits . . . " *Morash*, 490 U.S. at 115 (internal citations omitted). *See also* 29 U.S.C. § 1001(b). In other words, the primary purpose of ERISA is to ensure that private employers' benefits promises to their employees are kept.

These concerns are clearly implicated by an employer's promise to provide health insurance to its employees, because under this arrangement the employer remains ultimately responsible for "providing" the benefits. 29 U.S.C. § 1002(1). The employer, when negotiating the health insurance contract, gives shape to the plan by deciding, for

example, which treatments will be covered or how claims will be processed. And if the insurance company does not fulfill its contractual obligation to deliver the contemplated benefits to the employees, the employer, as an ERISA fiduciary, can sue the insurer to make sure that the employer's promise to the employees is kept. *See* 29 U.S.C. §§ 1132(a)(2), (3).

As the Ninth Circuit explained, with the city payment option, "[t]he employer never negotiates or signs a contract with the City, and the employer has no control over the City's coverage decisions. When the City administers the HAP, it does not act as the employer's agent entrusted to fulfill the benefits promises the employer made to its employees." Pet. App. 26a. Nor does the employer enroll its employees with the HAP. The mere act of writing a check to the City on behalf of specified employees, and informing those employees that the check has been written, is not remotely comparable to a contractual relationship between an employer and a health insurance company.

And because the Ninth Circuit explained why third party insurance arrangements are ERISA plans even while the city payment option is not, Pet. App. 25a-26a, there is no basis for petitioner's assertion that the decision will cause courts to begin ruling that third-party contracts are not ERISA plans. *See* Pet. 36 ("employers will be able to avoid ERISA's fiduciary duty rules and its civil and criminal enforcement provisions merely by hiring a third-party to perform the bundle of plan-design and

administrative-and-fiduciary tasks inherent in any plan"). If a litigant had the audacity to make such an argument in a future case, the first authority a court would cite to reject it is the Ninth Circuit's decision below.

In fact, had the Ninth Circuit concluded that an employer creates an ERISA plan when it calculates its health care spending obligation and makes payments to the government, *this* would have created major problems in ERISA preemption law. For example, imagine that a local government, instead of adopting a program like San Francisco's, simply imposed a payroll tax to be used to fund a public health program for all persons who work in the jurisdiction. Nobody could reasonably contend that an employer creates an ERISA plan when it pays this payroll tax. Yet petitioner here has advocated a definition of "ERISA plan" that would include this scenario – the employer creates a plan simply by determining its spending obligation and satisfying that obligation by making a payment to the government, which the government then uses to fund a public health program that includes the employer's workers.

Another consequence of deeming the city payment option a "plan" would be that federal obligations (and liabilities) could be imposed on employers with respect to matters over which they have no control, such as the obligations to act as a fiduciary with respect to benefits provided to HAP participants, and to create and operate a system for

processing claims by HAP participants. Equally problematic, San Francisco public health officials who operate this entitlement program could be subjected to ERISA's regulatory regime simply because some employers chose to satisfy their health care spending obligations by writing a check to the City. These consequences underscore the serious flaws in the argument that the city payment option creates an ERISA plan.

Petitioner makes much of an *amicus* brief filed below by the former Secretary of Labor agreeing that the city payment option creates an ERISA plan. More noteworthy, however, is that none of the 28 judges involved in the proceedings below adopted this novel argument – not the district judge who ruled against the City, and not the eight circuit judges who dissented from denial of rehearing en banc. Moreover, the current Department of Labor has stated it is "considering issues in the case," Bob Egelko, *Obama administration mum on S.F. health plan*, S.F. Chron., July 20, 2009, at C1, so it would be wrong to assume that the former Secretary's brief is reflective of the current Administration's views.

Once it is understood that the city payment option does not create an ERISA plan, the language permeating the petition to the effect that the ordinance intrudes on "plan regulation" is revealed to be widely off the mark. *See, e.g.*, Pet. 28 (arguing decision below allows local governments to "regulate ERISA plans themselves by first requiring their establishment and then dictating what benefits the

plan provides . . . "). Such assertions depend on the assumption that the city payment option creates a plan, and the petition unravels when that assumption is removed.

III. THE DECISION BELOW IS CONSISTENT WITH THIS COURT'S ERISA PREEMPTION RULINGS.

At the end of the day, petitioner's preemption argument is based on the assumption that employers are entitled to *expenditure* uniformity in areas mentioned by the ERISA statute. That assumption is wrong – ERISA does not insulate businesses from being required to spend money in these areas. ERISA protects *plan* uniformity for employers, but "cost uniformity was almost certainly not an object of pre-emption . . . " *Travelers*, 514 U.S. at 662.

This is illustrated by *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987), which makes clear that states and localities may regulate expenditures on benefits mentioned in ERISA (in that case severance pay), so long as they do not require adoption or alteration of ERISA plans:

> Appellant's basic argument is that any state law pertaining to a type of employee benefit listed in ERISA necessarily regulates an employee benefit plan, and therefore must be pre-empted. Because severance benefits are included in ERISA, *see* 29 U.S.C. § 1002(1)(B), appellant argues that ERISA pre-empts the Maine statute. In effect,

> appellant argues that ERISA forecloses virtually all state legislation regarding employee benefits. This contention fails, however, in light of the plain language of ERISA's pre-emption provision, the underlying purpose of that provision, and the overall objectives of ERISA itself. . . . ERISA's pre-emption provision does not refer to state laws relating to "employee benefits," but to state laws relating to "employee benefit *plans*". . . . The words "benefit" and "plan" are used separately throughout ERISA, and nowhere in the statute are they treated as the equivalent of one another. Given the basic difference between a "benefit" and a "plan," Congress' choice of language is significant in its pre-emption of only the latter.

482 U.S. at 7-8 (emphasis in original).

Two other cases in which the Court upheld local regulation of benefits mentioned in ERISA were *Dillingham* and *Morash*. In *Dillingham*, the state's regulation of apprenticeship programs created powerful incentives for those programs to alter their conduct, and may have affected employer costs, but that was not sufficient to establish preemption. 519 U.S. at 332. In *Morash*, the state's requirement that employers reimburse employees for unused vacation time obviously affected employers' costs, but there was no preemption in that case because the requirement did not regulate ERISA plans. 490 U.S. at 114-15.

In the area of health care itself, ERISA contemplates that employers will be subject to disparate costs across jurisdictions. If the goal of

ERISA preemption had been health care expenditure uniformity, Congress would not have included the savings clause, which exempts from preemption state laws regulating insurance. 29 U.S.C. § 1144(b)(2)(A). The savings clause has resulted in the enactment of more than 1,961 mandates on health insurance, and no two states impose identical sets of coverage mandates. Victoria Craig Bunce et al., *Health Insurance Mandates in the States*, Council for Affordable Health Insurance (2008 ed.) at 1. Accordingly, the cost of employer-provided health insurance varies dramatically from state to state. *Id.* at 3-5. "Such disuniformities . . . are the inevitable result of the congressional decision to 'save' local insurance regulation." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985). And that is why "cost uniformity was almost certainly not an object of pre-emption, just as laws with only an indirect economic effect on the relative costs of various health insurance packages in a given State are a far cry from those 'conflicting directives' from which Congress meant to insulate ERISA *plans*." *Travelers*, 514 U.S. at 662.[6]

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[6] Petitioner asserts that the preemption provision was meant to preclude bare health care spending requirements at the state or local level. Pet. 4-5 & n.13. But it does not point to a single word in ERISA's voluminous legislative history to support this conclusion. And although one former Congressional staffer has claimed that the provision was designed in part to preempt the Hawaii health care statute in existence at the time, *id.*, that statute was not a general expenditure requirement; it required that employers actually adopt employee welfare benefit plans. *See Agsalud*, 633 F.2d at 766.

Petitioner also makes much of the possibility that a local requirement in one jurisdiction might affect an employer's decisions about benefit expenditures in other jurisdictions. But the local severance and vacation pay requirements in *Fort Halifax* and *Morash*, the hospital surcharges upheld in *Travelers*, and the apprentice regulations upheld in *Dillingham* may all provide employers with some incentive to decrease spending on benefits in other jurisdictions. These cases demonstrate that ERISA's preemption provision was never intended to provide employers with umbrella protection against laws that might simply change the mix of economic incentives to increase or reduce benefit expenditures.

Petitioner and its allies disregard all of this, and instead rely upon an analytical sleight-of-hand that blurs the distinction between "expenditures" or "benefits" on the one hand, and "plans" on the other. For example, one brief asserts that "[t]he need to monitor *expenditures* in multiple jurisdictions is squarely at odds with ERISA's purpose of establishing a uniform system of *plan* regulation."[7] Similarly, petitioner quotes *Travelers* as saying that the purpose of ERISA preemption is to "'avoid a multiplicity of regulation in order to permit the nationally uniform

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[7] Brief for the Retail Industry Leaders Association and the Chamber of Commerce of the United States of America as *Amici Curiae* in Support of Petitioner ("RILA") at 14 (emphasis added).

administration' of employee benefits." Pet. 22 (quoting *Travelers*, 514 U.S. at 657). What *Travelers* actually says is that the purpose of ERISA preemption is to "avoid a multiplicity of regulation in order to permit the nationally uniform administration of *employee benefit plans*." *Travelers*, 514 U.S. at 657 (emphasis added).

When the distinction between expenditures and plans is brought back into focus, it becomes clear that there is no conflict with the two decisions primarily relied upon by petitioner and its allies: *Egelhoff* and *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125 (1992).

The Washington statute in *Egelhoff* provided that, in the event a couple divorces, and then one member of the couple dies after the divorce, the survivor is not entitled to the benefits of the dead spouse's ERISA plan, even if the plan does not include such a limitation on the rights of the divorced survivor. 532 U.S. at 147. Washington argued the statute was not preempted because it exempted ERISA plans which explicitly provided that divorced spouses should receive plan benefits. Thus, Washington argued, there were two ways plan administrators could comply with the statute: (1) by administering their plans differently in Washington; or (2) by changing the terms of their plans to include specified language. But the Court held this did not save the statute from preemption, because *both* compliance options required plan administrators to

change the way they wrote or administered their plans: "Plan administrators must either [disregard the language of their plans and] follow Washington's beneficiary designation scheme or alter the terms of their plan so as to indicate that they will not follow it." *Id.* at 150.

And it is in this context that the *Egelhoff* Court expressed concern with the need to "maintain a familiarity with the laws of all 50 States." 532 U.S. at 151. If a law forces a plan administrator to *change its ERISA plan* in a given state, that goes to the core of what ERISA's preemption provision guards against – the possibility of plan administrators being forced to "maintain a familiarity with the laws of all 50 States so that they can *update their plans* as necessary to satisfy the opt-out requirements of other, similar statutes." *Id.* at 151 (emphasis added). Under the HCSO, employers must track their health care expenditures, just as they must already keep track of wages and other payroll matters. But they are not forced to change anything in their plans to comply with the ordinance.[8]

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[8] Similarly, the statement in *Egelhoff* that the "tailoring of plans *and employer conduct* to the peculiarities of the law of each jurisdiction is exactly the burden ERISA seeks to eliminate" does not have the broad meaning petitioner gives it. 532 U.S. at 151 (citation and quotations omitted, emphasis added). ERISA does not protect employers from tailoring their conduct to local requirements with respect to everything; it protects them from tailoring their conduct with respect to plans.

Nor does the decision below conflict with *Greater Washington*. Petitioner argues that both the HCSO and the ordinance struck down in *Greater Washington* make unlawful "reference to" ERISA plans because they involve measuring compliance with reference to an existing ERISA plan. However, as the Court explained in *Dillingham*, a local law makes an unlawful "reference to" an ERISA plan if the law "acts immediately and exclusively upon ERISA plans," or if the "existence of ERISA plans is essential to the law's operation." *Dillingham*, 519 U.S. at 325. That was true of the ordinance in *Greater Washington* because an employer's obligation was triggered *directly by* the benefits it offered through an ERISA plan – whatever ERISA benefits the employer offered, the employer had to provide those same benefits to injured employees on workers' compensation. 506 U.S. at 126-27. If the employer had no ERISA plan, there was no obligation. Here, the HCSO operates on employers "irrespective of the existence of an ERISA plan." *Dillingham*, 519 U.S. at 328 (quotations and ellipses omitted).

Finally, some *amici* attempt to conjure up a conflict with Supreme Court precedent by selectively quoting the language of a Ninth Circuit decision that this Court summarily affirmed: *Local Union 598 v. J.A. Jones Constr. Co.*, 846 F.2d 1213 (9th Cir.), *summarily aff'd*, 488 U.S. 881 (1988). *See* RILA Br. at 8. They argue that the HCSO, by generally

mandating health care expenditures, is imposing a "contribution" mandate of the kind struck down in *J.A. Jones*. RILA Br. at 8. But again, this blurs the distinction between general expenditures and plans. The full quotation from *J.A. Jones* further underscores this distinction:

> [The statute] mandates a particular level of contributions by employers *to employee benefit plans*. . . . A statute which mandates employer contributions *to benefit plans* and which effectively dictates the level at which those required contributions must be made has a most direct connection with an employee benefit plan.

846 F.2d at 1219 (emphasis added).

In sum, no Supreme Court decision invalidates a bare expenditure requirement that provides employers with a reasonable, non-ERISA compliance option. To the contrary, the Ninth Circuit's ruling is fully supported by this Court's precedent.

IV. NUMEROUS OTHER FACTORS COUNSEL AGAINST A GRANT OF CERTIORARI.

A. Petitioner Greatly Exaggerates The Impact Of The Ninth Circuit's Ruling.

Petitioner and its *amici* contend the Ninth Circuit's ruling will cause an avalanche of "pay or play" laws to crumble down upon multijurisdictional employers. They dramatically overstate both the

possibility this will occur, and the impact it would cause.

As a preliminary matter, petitioner and its allies focus primarily on *proposals*, not actual laws. And their primary citation is to a law review article from 2006 – two years prior to when the Ninth Circuit first upheld the HCSO. *See, e.g.*, Pet. 20. Most of those proposals are long dead.[9]

As for the four measures that actually became law, petitioner and its *amici* neglect to discuss whether the Ninth Circuit's reasoning applies to those laws. It does not. The first law, from Suffolk County, New York, has already been struck down on the same ground relied upon by the Fourth Circuit: none of the purported non-ERISA compliance options was truly available to Wal-Mart, thereby effectively forcing Wal-Mart to alter its ERISA plan. *See Retail Indus. Leaders Ass'n v. Suffolk County*, 497 F. Supp. 2d 403, 417-18 (E.D.N.Y. 2007). The second law creates a board charged with establishing a universal health care program in Connecticut by mid-2010, but does not mention an employer spending requirement

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[9] *See* H.R. 1316, 2d Reg. Sess. (Colo. 2006); S. 1618, 107th Reg. Sess. (Fla. 2006); S.B. 87, 94th Leg., 1st Reg. Sess. (Mich. 2007); S.B. 2684, 2006 Reg. Sess. (Miss. 2006); A.B. 1966, 213th Leg. (N.J. 2008); H.B. 258, 2006 Sess. (Va. 2006); H.B. 2517, 59th Leg., 2d Sess. (Wash. 2005); H.B. 4024, 77th Leg., 2d Sess. (W. Va. 2006); A.B. 860, 97th Leg., 2005-06 Sess. (Wis. 2005); H.B. 1703, 159th Sess., 2d Year (N.H. 2006).

or explain how the program will be funded. *See* 2009 Conn. Legis. Serv., Pub. Act No. 09-148 (West). Finally, Massachusetts, Vermont and New York City adopted employer health care spending requirements that include an option of making a payment to the government, but those payments, to use the words of the Ninth Circuit, give "nothing in return – either to an employer or its employees – for the employer's payment to the State," beyond what any other qualifying resident would receive. Pet. App. 37a. *See* 2006 Mass. Legis. Serv. Ch. 58 (West); 114.5 Mass. Code Regs. 16.01-.05; Vt. Stat. Ann. tit. 21, § 2003 (2009); N.Y.C. Admin. Code § 22-506.

That no other jurisdiction has enacted a program like San Francisco's, either before or after the Ninth Circuit's initial published opinion in January 2008, is unsurprising. It would be extraordinarily difficult for other jurisdictions to establish the type of non-ERISA compliance option provided by San Francisco's ordinance: payment into a comprehensive, government-run health care program that the City invested significant public dollars to build, and spends significant tax dollars to maintain. And as discussed further below, other jurisdictions are particularly unlikely to make such investments while Congress debates national health care reform, which could well include a uniform federal employer health care mandate.

Petitioner goes on to assert that if additional San Francisco-type programs do come into being, this would "overload the largest human resources

departments and the most expensive software-systems." Pet. 38. That is preposterous. As discussed above, employers commonly face differing cost (and recordkeeping) requirements in different jurisdictions, including severance pay requirements, minimum and prevailing wage requirements, vacation pay requirements, apprenticeship and/or training program requirements, taxes, tax credits, fees, and sick leave requirements. Such is the unavoidable, unremarkable consequence of doing business in multiple jurisdictions in the United States. And as discussed more fully by *amicus curiae* Nibbi Bros. Associates, multijurisdictional employers already regularly use payroll and other human resources software, provided by companies like ADP and Oracle, that are geared to facilitate compliance with disparate local requirements of this kind.

Petitioner and its allies also fail to account for the HCSO regulations that make it particularly easy for multijurisdictional employers to establish compliance. For example, one *amicus* brief asserts the ordinance will "require employers [with self-insured plans] to create a special pool of funds for San Francisco employees that is separate from the rest of the employees covered by the company plan." RILA Br. at 13. In truth, a large, multijurisdictional employer with a self-insured plan need only establish that it has spent a certain amount per employee *plan-wide*. *Supra* at 4-5. The same is true of a large employer that provides uniform health coverage to its employees through a traditional insurance plan. *Id.*

Of course, if petitioner is correct that numerous laws will sprout up and that they will be unworkable for employers, this also means the Court will have ample opportunity to consider this ERISA preemption issue in future cases. And as discussed below, future cases would have much better records.

B. The Case Is A Poor Vehicle For Consideration Of Most Arguments Made By Petitioner And Its Allies.

Two key contentions in this case have been: (i) the city payment option is not a rational choice for employers; and (ii) the ordinance imposes intolerable administrative burdens on employers. Although there was discovery in the district court, petitioner proffered no evidence to support either contention. Indeed, the record contains significant evidence to refute them both. Accordingly, this case presents a poor vehicle for consideration of an employer's claim that a general health care spending requirement is preempted by ERISA.

With respect to the argument that the city payment option is not a "rational decision" for employers,[10] petitioner had the burden of making this showing. *See, e.g., Dillingham*, 519 U.S. at 333 ("it has not been demonstrated here that the added

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[10] Brief of *Amici Curiae* the ERISA Industry Committee and National Business Group on Health in Support of Petitioner at 17.

inducement created by the wage break available on state public works projects is tantamount to a compulsion upon apprenticeship programs"); *Travelers*, 514 U.S. at 664 ("no showing has been made here that the surcharges are so prohibitive as to force all health insurance consumers to contract with the Blues"). However, in contrast to *Fielder*, where Wal-Mart presented unrebutted evidence that Maryland's law would force it to alter its ERISA plan, 274 F.3d at 193, petitioner submitted no evidence and made no showing that the choice between setting up an ERISA plan and using the city payment option was remotely a "Hobson's choice" for any employer. *Travelers*, 514 U.S. at 664. In fact, at oral argument in the Ninth Circuit, counsel for petitioner conceded that, if anything, employers had an incentive to *choose* the city payment option, which contradicted the central contention in petitioner's briefs in the district court and the Ninth Circuit.[11] And in contrast to petitioner's non-showing, the City presented unrebutted evidence that the city payment option provides a reasonable alternative. *Supra* note 3.

Petitioner also relies heavily on the argument that the HCSO's recordkeeping and other administrative obligations are burdensome. Again, this argument is made only at the highest level of abstraction. Petitioner presented no evidence to

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[11] *See* http://www.ca9.uscourts.gov (Audio Files, No. 07-17370, first entry, minutes 31:00-34:20).

refute the common-sense notion that employers keep records of hours worked, and health care dollars spent, in the normal course of business. Nor did it present any other evidence of the exorbitant administrative burden it now alleges. The only evidence below demonstrated that one of petitioner's member restaurants – Max's – already kept the key records, including hours worked per employee and health care expenditures per employee. Resp. App. 60-62. There is no basis, on this record, to conclude that the HCSO's recordkeeping obligations are anything other than *de minimis* for employers.

C. The Result Sought By Petitioner And Its Allies Would Have A Devastating Impact On The People Of San Francisco.

In contrast to the abstract assertions by petitioner and its allies about the impact of the Ninth Circuit's ruling, the result they advocate would have a real and devastating impact on San Francisco and its residents: the City would be thrust back into the health care crisis that left more than 82,000 people without coverage, and that imposed a tremendous strain on the taxpayers by forcing public emergency rooms to treat illnesses and injuries that could have been prevented. In just 1½ years, the number of uninsured declined from roughly 82,000 to under 23,000, and the number continues to go down. Use of public emergency rooms declined *seventy percent*. Resp. App. 25-30.

Nor is the care provided by the City to the previously uninsured limited to traditional "safety net" care. Those enrolled in the HAP are receiving essential preventive and diagnostic treatment for chronic conditions such as asthma, heart disease, diabetes, hypertension or cancer. Resp. App. 25-26.

To cite just one example, a former restaurant worker with a chronic heart condition, mitral valve prolapse, was unable to obtain health insurance. She needed surgery for her condition, which would have cost her more than $100,000 if performed at a private facility, rendering it unaffordable for her. Because this person was able to join the HAP, she obtained the surgery, and believes she might not still be alive today if she had been unable to obtain this service from the City's new program. Resp. App. 26-27.

As the City showed in its response to the stay application, the universal health care program cannot survive without the employer spending requirement. Resp. App. 28-29. *See also* Brief for Zazie Restaurant as *Amicus Curiae* in Support of Respondents. Thus, the result petitioner and its allies seek is to terminate San Francisco's successful, first-of-its-kind universal health care program, based on speculation and exaggeration about the as-yet unfelt impact of the Ninth Circuit's ruling on multijurisdictional employers.

D. The Potential Enactment Of Federal Health Care Legislation Counsels Against A Grant Of Certiorari.

Finally, the question presented by the petition may be mooted by national health care reform, so granting certiorari would not be a good use of the Court's resources. As petitioner and its allies point out, Congress is considering federal legislation that would include a national employer mandate. If the predictions of petitioner and its *amici* about the enactment of such a law are correct, it would be that new law, not ERISA, that preempts the City's health care spending requirement. And if that new law preempts local health care spending requirements, the ERISA preemption issue presented here would be relevant only for a relatively brief gap period, until the effective date of the legislation.

By the same token, if Congress does not enact health care reform legislation in the next several years, and if other localities then seek to emulate San Francisco's solution to the health care crisis, the Court will have another opportunity to take up the question at that time. Either way, the present state of flux regarding national health care reform counsels against Court intervention.

CONCLUSION

The Court should deny the petition for a writ of certiorari.

Respectfully submitted,

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APPENDIX A

NO. 08A824

IN THE SUPREME COURT OF
THE UNITED STATES

OCTOBER TERM, 2008

GOLDEN GATE RESTAURANT ASSOCIATION,
Applicant,

v.

CITY AND COUNTY OF SAN FRANCISCO,
Respondent,

SAN FRANCISCO CENTRAL LABOR COUNCIL; SERVICE EMPLOYEES INTERNATIONAL UNION ("SEIU"), LOCAL 21; SEIU UNITED HEALTHCARE WORKERS-WEST; and UNITE HERE! LOCAL 2,
Intervenor/Respondents,

On Application to The Honorable
Anthony M. Kennedy, Associate Justice of the
United States Supreme Court and Circuit Justice
for the Ninth Circuit, for Order Staying Mandate
and Vacating Stay of District Court Judgment

JOINT RESPONSE TO APPLICATION FOR ORDER STAYING MANDATE AND VACATING STAY OF DISTRICT COURT JUDGMENT

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[1] INTRODUCTION

The fatal flaw in the application filed by the Golden Gate Restaurant Association ("GGRA" or "association") is its failure to provide any reason for emergency intervention. In February 2008, one month after San Francisco's health care spending requirement took effect, the Circuit Justice denied GGRA's first application for a stay. Since that time,

the City's program has become fully operational, the medium and large employers covered by the ordinance have been complying with the spending requirement for 15 months, and tens of thousands of previously-uninsured workers now have health coverage under the City's program. There is no basis for disturbing this status quo while the normal certiorari process runs its course.

As a threshold matter, a stay may not issue unless the applicant has demonstrated a likelihood of irreparable harm. Not only has GGRA failed to demonstrate irreparable harm – it has not even *alleged* irreparable harm. The association skips over this prong of the test for a stay entirely, addressing only the three subsequent prongs. This alone requires denial of the stay application.

The closest the association comes to touching upon irreparable harm is its assertion that its members, by continuing to make health care expenditures as they have done for the past 15 months, "may" suffer harm for which there is "no effective remedy." App. at 26. Such a tepid assertion could not establish irreparable harm, even if GGRA had attempted to argue that it did. Indeed, putting aside the general rule that financial loss does not warrant the kind of relief GGRA now seeks, the evidence here suggests there is no financial harm at all. GGRA's members have passed the cost of the health care spending requirement on to their customers in the [2] form of a health care surcharge, which severely undermines any claim of financial

harm. *See* Declaration of Vince Chhabria in Opposition to Application for Order Staying Mandate. In fact, just days after GGRA submitted this application, the association's own director admitted that the health care spending requirement is "working all right now." H. Knight, *Not all restaurants back suit over Healthy S.F.,* San Francisco Chronicle, Mar. 22, 2009 at B-1 (CCSF Appendix, Ex. A).

Nor would a balancing of the equities justify a stay. In addition to the alleged financial harm to its members, GGRA contends that maintenance of the current status quo would inflict harm on businesses nationwide. The association speculates that other state or local governments might emulate San Francisco's program, thereby requiring multi-jurisdictional employers to keep track of more than one local health care spending requirement. This argument primarily goes to the merits of GGRA's preemption challenge. But to the extent GGRA means to argue that laws similar to San Francisco's will crop up before the certiorari process runs its course (and that this somehow would provide a legal basis for emergency intervention), the argument is baseless. Although GGRA makes opaque reference to "similar" measures having been "proposed," it does not, and cannot, point to the actual enactment of a single law similar to San Francisco's since the Court of Appeals allowed the program to take effect 15 months ago. In fact, GGRA does not even cite a *proposal* that was made after San Francisco's program took effect – it cites only a law

review article from 2006 that listed laws proposed before the litigation even began.

Pitted against these alleged harms to the association are the very real harms that GGRA's application seeks to inflict upon the City and its [3] residents. As a result of the employer spending requirement, more than 37,000 San Francisco workers are now covered through the City's program. Staying the lower court decision, and thereby enjoining the health care spending requirement, would cause these workers to lose their coverage and access to critical diagnostic and preventive care and treatment. Moreover, elimination of the spending requirement could outright destroy San Francisco's new health care program, forcing the City to revert to the old, failed model of providing emergency care to uninsured people at public hospitals once it is too late to administer proper preventive and diagnostic care.

Aside from the equities, the case is not worthy of certiorari. Far from creating a split with the Fourth Circuit's ruling in *Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180 (4th Cir. 2007), the decision below operates in harmony with that ruling to stand for the proposition – well established by prior case law – that local governments may impose expenditure requirements on employers so long as those requirements do not interfere with plan uniformity. Moreover, the Court need not rush to decide this legal question, because the likelihood is low that other jurisdictions would quickly adopt similar health care programs. Both the success and legality of San

Francisco's program depend on the existence of a comprehensive, government-run health care delivery system that operates at great expense to the City's taxpayers. Particularly given current economic conditions, it is unrealistic to expect that other jurisdictions will rush to follow suit.

In addition, one outcome of the current debate on national health care reform could be to obviate the need for local governments to regulate in this area. Indeed, national health care legislation could moot the legal [4] question at hand, either by preempting programs like San Francisco's or by expressly authorizing them. This possibility suggests the Court should avoid venturing into the national debate on health care reform by deciding a weighty ERISA preemption question that could be mooted before it ever arises again.

Finally, even if certiorari were granted, it is unlikely the Court would reverse the decision below. GGRA's argument on the merits is that employers have the right not to be required to spend money in areas, like health care, mentioned by the ERISA statute.[1] This fails to recognize the distinction between plan uniformity, which ERISA's preemption provision protects, and expenditure uniformity, which it does not. As the Court has stated, "cost uniformity was almost certainly not an object of pre-emption . . ." *New York State Conf. of Blue Cross & Blue*

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[1] 29 U.S.C. § 1002(1).

Shield Plans v. Travelers Ins. Co, 514 U.S. 645, 662 (1995). And as the Court has explained in cases such as *Fort Halifax Packing Co., Inc. v. Coyne,* 482 U.S. 1 (1987) and *Massachusetts v. Morash,* 490 U.S. 107 (1989), there is a reason ERISA's preemption provision explicitly singles out employee benefit "plans," rather than covering employee benefits generally. *See, e.g., Fort Halifax,* 482 U.S. at 115 ("Given the basic difference between a 'benefit' and a 'plan,' Congress's choice of language is significant in its pre-emption of only the latter"). States and localities may regulate the benefits mentioned in ERISA so long as they do not require alteration of ERISA plans. Because that is precisely what San Francisco's ordinance does, it is not preempted.

[5] STATEMENT

A. The Health Care Security Ordinance

Because GGRA's description of the ordinance is incomplete, and because its discussion of the effects of the ordinance on employers and their ERISA plans is inaccurate, we provide a brief description here.

In 2006, roughly 82,000 San Francisco adults suffered from a lack of health insurance – more than one-tenth of the City's population. CCSF Appendix, Ex. B at 3.[2] In response to this health care crisis, the

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[2] A common misconception about the uninsured is that they are "taken care of" because they qualify for state or federally funded health care programs for the indigent like Medi-Cal

(Continued on following page)

San Francisco Board of Supervisors unanimously passed, and the Mayor signed into law, the Health Care Security Ordinance ("HCSO" or "ordinance"). The ordinance has two key related components – a government health care program and an employer health spending requirement.

The government health care program is operated by the San Francisco Department of Public Health ("DPH"). Its primary feature is the Health Access Program ("HAP"), which delivers health care to its participants from a network consisting of San Francisco General Hospital, DPH clinics, and participating non-profit and private providers. S.F. Admin. Code § 14.2(a).[3] The HAP assigns a primary care physician, nurse practitioner or physician assistant to each participant. And it provides "medical services with an emphasis on wellness, preventive care and [6] innovative service delivery." S.F. Admin. Code § 14.2(f). Among the specific services provided are inpatient and outpatient hospital services, diagnostic and laboratory services, radiological services, mental

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(California's Medicaid program). In reality, most people without health care do not qualify for such programs; rather, they simply go without care or resort to trips to the emergency room when it is too late to receive proper preventive treatment (and then are billed for the high cost of such trips). The 82,000 San Francisco residents who were uninsured do not include the people who were already enrolled in San Francisco's indigent health care programs. CCSF Appendix, Ex. B at 4.

[3] The ordinance, along with the implementing regulations, can be found at CCSF Appendix, Ex. B.

health services, home health care, and prescription drug benefits. *Id.* The value of this care is substantial – DPH estimated that in 2008 it cost an average of $261 per participant per month to provide it.[4] CCSF Appendix, Ex. B at 5.

The HAP, which is funded in large part by the City's general fund, is available to uninsured San Francisco residents, regardless of whether they are employed or unemployed. Enrollees must pay quarterly participation fees to receive HAP coverage.[5]

The other key component of the HCSO is the employer spending requirement – a mandate that medium and large businesses make minimum health expenditures on behalf of employees who work more than a specified number of hours. Specifically, in 2008 private employers with 20-99 employees and nonprofit employers with 50 or more employees were

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[4] Incidentally, DPH changed the name of the HAP program to "Healthy San Francisco" after determining that the name "Health Access Program" would create confusion among San Francisco residents because of its similarity to other programs. See DPH Reg. No. 1(b). For purposes of this litigation the parties have continued to use the name contained in the ordinance.

[5] Individual residents who work in San Francisco but live elsewhere do not qualify for HAP participation, but the program contains a feature for those people as well. The ordinance authorizes DPH to establish and maintain medical reimbursement accounts for qualified nonresident employees who work in the City. S.F. Admin. Code §§ 14.1(b)(7), 14.2(g). Beneficiaries of this aspect of the City's program may draw from their accounts to obtain reimbursement for medical expenses, including payments of health insurance premiums. DPH Reg. No. 7(g)(i).

required, for any employee who has been employed for 90 days and works more than ten hours per week, to make health care expenditures of $1.17 per hour on behalf of that employee. Private employers with 100 or more employees were required to make health care expenditures of $1.76 per [7] hour on behalf of each covered employee. S.F. Admin. Code. § 14.1(b)(8); OLSE Reg. No. 5.2(A)(1).[6]

It is entirely up to each covered employer to decide how to comply with this spending requirement. The Ordinance defines health care expenditures to mean "any amount paid by a covered employer to its covered employees or to a third party on behalf of its covered employees for the purpose of providing health care services for covered employees or reimbursing the cost of such services for its covered employees." S.F. Admin. Code § 14.1(b)(7). The ordinance makes clear that employers may set up health care plans themselves, or, of they prefer not to do so, they may make payments to the City on behalf of their workers (hereinafter "the city payment option"). *Id.* They may also fulfill the expenditure obligation through a combination of the two. The program is structured so that, if an employer chooses the city payment option,

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[6] The amount has increased slightly for 2009: $1.85 per hour for large employers and $1.23 per hour for medium employers. OLSE Reg. No. 5.2(B). GGRA has argued that the amount will skyrocket after 2010, CCSF Appendix, Ex. A, but that is false, and in any event, not relevant to whether a stay should be in effect during the certiorari process.

it need only write a check and all employees on whose behalf the payment is made will be eligible to receive health care benefits.

Covered employees who qualify for HAP membership are, if their employers choose to satisfy the spending requirement by paying the City, entitled to enroll in the program at a 75% discount on the quarterly participation fees they would otherwise be required to pay. DPH Reg. No. 7(f). Furthermore, any covered employee whose fee, after the 75% discount, falls below $50 per quarter is simply allowed to enroll for free. *Id.*

[8] According to studies compiled by the San Francisco Controller's Office, the large majority – approximately ninety percent – of businesses with 20 or more employees already provided health care benefits to their employees at the time the ordinance was enacted. CCSF Appendix, Ex. B at 9. The average monthly health insurance premium in California at that time was $379. *Id.*

The employer health care spending requirement has now been in effect for 15 months. As a result, 37,000 San Francisco workers are covered under the government health program described above. Declaration of Dr. Mitchell H. Katz in Opposition to Application for Order Staying Mandate at ¶ 11. Thousands of others are enrolled in the program separate and apart from any payment made by an employer. *Id.* Overall, the number of San Francisco

residents without health coverage is down to under 23,000, and counting. *Id.* at ¶10.

B. Procedural Background

On December 26, 2007, the district court ruled that the ordinance was preempted by ERISA. The next day, the City and Intervenors filed an emergency application with the United States Court of Appeals for the Ninth Circuit, seeking an order staying the district court's ruling and allowing the employer spending requirement to take effect pending appeal. On January 9, 2008, the Ninth Circuit granted this request, ordered expedited briefing, and set an accelerated date for oral argument on the merits. *Golden Gate Restaurant Ass'n v. City and County of San Francisco,* 512 F.3d 1112 (9th Cir. 2008).

After waiting more than one month after the emergency application was granted, GGRA filed an application for a stay of the Ninth Circuit's order with the Circuit Justice. GGRA made arguments that are precursors [9] to the ones it raises in the present application, namely, that restaurants could suffer financial harm if the spending requirement were allowed to take effect, that the ordinance would require them to keep records, and that businesses could be subject to multiple health care spending obligations as a result of the ordinance. The Circuit Justice denied the stay application. *Golden Gate Restaurant Ass'n v. City and County of San Francisco,* Sup. Ct. Case No. 07A654.

Oral argument on the merits in the Court of Appeals took place on April 17, 2008, and the panel issued its ruling on September 30, 2008, reversing the district court and concluding San Francisco's ordinance is not preempted. *Golden Gate Restaurant Ass'n v. City and County of San Francisco*, 546 F.3d 639 (9th Cir. 2008) ("*GGRA II*"). GGRA did not ask the panel for a stay at that time. Instead, it filed a petition for rehearing en banc (but it did not ask the en banc court for a stay either). The en banc petition was denied on March 9, 2009. GGRA Appendix, Ex. F. The mandate issued on March 17, 2009. Meanwhile, San Francisco's health care spending requirement has been in effect, the restaurants and other employers have been complying with it, and 37,000 workers obtained health coverage from the City's program as a result.

STANDARD OF REVIEW

An application for a stay brought pursuant to Supreme Court Rule 23.1 and 28 U.S.C. § 2101(f) may not be granted unless: (1) the applicant demonstrates a likelihood of irreparable harm; (2) the equities favor a stay; (3) there is a reasonable probability that four members of the Court would consider the underlying issue worthy of certiorari; and (4) there is a significant possibility that the Court will reverse the decision below. *See, e.g., Certain Named and Unnamed Non-citizen Children and Their Parents* [10] *v. Texas*, 448 U.S. 1327, 1330 (1980) ("*Non-citizen Children*") (Powell, J., in chambers).

It bears emphasis that if an applicant fails to demonstrate a likelihood of irreparable harm, the stay application must be denied for that reason alone, rendering consideration of the other elements of the test unnecessary. *See Whalen v. Roe*, 423 U.S. 1313, 1316 (1975) (Marshall, J., in chambers) (conclusion that applicant has shown no irreparable harm "necessarily decides the application and renders unnecessary" any consideration of the remaining elements). *See also Ruckelshaus v. Monsanto Co.*, 463 U.S. 1315, 1317 (1983) (Blackmun, J., in chambers).

However, if an applicant does demonstrate irreparable harm, this does not obviate the need to inquire whether the equities justify a stay, including whether a stay would be in the public interest. "It is ultimately necessary, in other words, 'to balance the equities – to explore the relative harms to applicant and respondent, as well as the interests of the public at large.'" *Barnes v. E-Systems, Inc.*, 501 U.S. 1301, 1305 (1991) (Scalia, J., in chambers) (quoting *Rostker v. Goldberg*, 448 U.S. 1306, 1308 (1980) (Brennan, J., in chambers)). *See Generally* R. Gressman, K. Geller, S. Shapiro, T. Bishop & E. Hartnett, Supreme Court Practice 873 (9th. ed. 2007).

More generally, in the context of an in-chambers stay application, there is a "presumption that the decisions below – both on the merits and on the proper interim disposition of the case – are correct." *Rostker*, 448 U.S. at 1308. Accordingly, a Circuit Justice "will grant a stay only in extraordinary circumstances." *Bartlett v. Stephenson*, 535 U.S. 1301,

1304 (2002) (Rehnquist, C.J., in chambers) (quoting *Whalen*, 423 U.S. at 1316). *See, e.g., CBS Inc. v. Davis*, 510 U.S. 1315, 1317 (1994) (Blackmun, in [11] chambers) ("extraordinary circumstances" present where lower court ruling would lead to "indefinite delay" of broadcast that would "cause irreparable harm to the news media that is intolerable under the First Amendment").

ARGUMENT

I. GGRA HAS FAILED TO ALLEGE, MUCH LESS ESTABLISH, IRREPARABLE HARM.

There is a fatal omission in GGRA's application. It argues three of the four requirements for a stay: that there is a reasonable probability the Court will grant certiorari, App. at 8, that there is a significant possibility the Court will reverse the decision below, App. at 12, and that the "balance of equities" favors the association. App. at 24. But the application completely omits any discussion of whether there is a likelihood of irreparable harm. GGRA has submitted no evidence, made no factual assertions, and advanced no legal argument about irreparable harm. Accordingly, no further inquiry is needed – the application must be denied for failure to allege, much less demonstrate, irreparable harm. *See* p. 11, *supra*.

The only portion of the application that could be construed as relating to irreparable harm (even though GGRA does not characterize it as such) is the statement that, absent a stay, restaurants with more

than 20 employees will continue making health care expenditures under the ordinance, as they have done for the past 15 months. GGRA asserts that there "may" not be an "effective remedy" for this alleged injury. App. at 26. Putting aside the general rule that monetary injury does not give rise to relief of this kind, *cf. Non-citizen Children*, 448 U.S. at 1332-34, in this case the evidence indicates there has been no financial harm at all – irreparable or otherwise. Shortly after the program took effect, restaurants in San Francisco began passing the cost of the health care spending [12] requirement on to their customers, in the form of a "Healthy San Francisco" surcharge. *See* Chhabria Decl., Ex. A (receipts and menus reflecting surcharge). Indeed, because restaurants have successfully passed on this cost, and because San Francisco restaurant patrons have been widely supportive of it, GGRA's own director has publicly stated that the health care expenditure requirement is "working all right now." CCSF Appendix, Ex. A. This statement from GGRA's director came just days after GGRA submitted its emergency application to the Circuit Justice. Perhaps that is why GGRA is unwilling to allege its members suffer from irreparable financial harm.

II. THE EQUITIES MILITATE STRONGLY AGAINST A STAY.

Even if one were to assume irreparable harm despite GGRA's failure to allege it, the equities would

not justify a stay. In fact, compared to when GGRA sought a stay from the Circuit Justice 13 months ago, the equities in favor of the City and its residents are now much stronger. Back then, the City had only begun implementing its program, the medium and large employers impacted by the spending requirement had not yet developed their systems for making health care expenditures, and workers had not yet obtained health coverage as a result of payments by their employers. Now, the program is fully operational, the medium and large employers have been making their payments, and roughly 37,000 workers enjoy health coverage from the City as a result. A stay would disturb this status quo by stripping people of their health coverage, and could potentially destroy the City's new universal health program in the process.

[13] **A. The Harm To GGRA And To Other Businesses Is Minimal.**

Aside from GGRA's tepid and unsupportable assertion of financial hardship, the association claims its members are being harmed by the ordinance's recordkeeping requirements. App. at 26. But those requirements are neither onerous nor complex. GGRA's members must maintain itemized pay statements, which is already mandated by California Labor Code section 226. The ordinance requires them to maintain the name, address, phone number and first day of work of each employee, and records of health care expenditures made on behalf of those

employees. And they must file annual reports with the City to prove quarterly compliance, which simply involves dividing the amount spent on health care by the hours worked by covered employees. S.F. Admin Code § 14.3. GGRA has not explained how maintaining these records or reporting this information would harm its members. Indeed, GGRA has not explained why such information would not already be maintained in the normal course of business.

Beyond the purported recordkeeping hardship for GGRA's members, the association makes passing reference to alleged financial and recordkeeping hardship that other San Francisco employers covered by the ordinance would suffer if the program continues during the certiorari process. However, no other San Francisco employer has challenged the validity of the program, and accordingly there is no reason to assume that businesses other than some of GGRA's members consider themselves harmed by it. Indeed, the great majority of medium and large employers in San Francisco actually benefit from the health care spending requirement, because they were already providing health insurance to their employees. CCSF Appendix, Ex. B at 9. Any employer that previously spent enough [14] money on health care to satisfy the ordinance is no longer at a competitive disadvantage vis-a-vis the minority of

medium and large employers that had chosen not to spend money on employee health benefits.[7]

GGRA next asserts that the decision below inflicts harm beyond San Francisco, because it could cause multi-jurisdictional employers to be subjected to a flood of different health care spending obligations. To the extent GGRA means to contend that multi-jurisdictional employers will be subjected to different spending obligations *during the certiorari process,* that is without any support. GGRA has not identified a single piece of legislation that has even been proposed, much less enacted, since the Court of Appeals allowed San Francisco's program to take effect 15 months ago. Instead, it cites a law review article from 2006 – before San Francisco's ordinance was even enacted – for the proposition that "over thirty similar statutes *had been* proposed . . . " App. at 9 (emphasis added). The claim of impending nationwide hardship during the certiorari process is illusory.

Even if proposals like the ones listed in GGRA's law review article were pending today, this still would not be a hardship. First, many of those proposals were similar or identical to the Maryland law struck

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[7] Moreover, even those medium and large employers whose health care spending was affected by the ordinance have received a benefit, because their employees have received health coverage as a result, thereby blunting any claim of harm to those busiresses.

down by the Fourth Circuit, and dramatically different from the ordinance San Francisco has enacted.[8] As discussed in Section III, the Ninth Circuit explained that San Francisco's ordinance was not preempted precisely because of its differences from the Maryland law. Second, the claim of hardship for [15] multi-jurisdictional employers presumes that GGRA is correct on the merits – specifically, that local governments may not impose spending requirements on employers. But as discussed in Section IV, this Court has already made clear that ERISA does not protect employers from local payment requirements merely because they apply to areas mentioned by ERISA.

GGRA's final claim of hardship relates in some fashion to the stimulus package recently passed by Congress and signed into law by the President. App. at 25. The association observes that the ordinance, by allowing San Francisco employers to comply with the health care spending requirement by making payments to the City for their employees' benefit, has given those employers a means to provide health coverage that would not be covered by COBRA. It is difficult to understand what hardship this creates. GGRA seems to be assuming that workers who received no coverage prior to the ordinance, but who

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[8] *See., e.g.*, Senate Bill No. 1414, 2005-2006 Reg. Sess. (Cal. 2006); House Bill No. 2579, 81st Leg., 2006 Reg. Sess. (Kan. 2006); House Bill No. 2517, 59th Leg., 2006 Reg. Sess. (Wash. 2006).

now receive comprehensive coverage from the City, are worse off than before because COBRA does not apply to the HAP. This makes no sense. GGRA's invocation of COBRA and the stimulus package appears to be nothing more than an attempt to manufacture one issue not already presented in its unsuccessful stay application from last year.

B. A Stay Would Impose Substantial Hardship On The City And Its Residents.

Since San Francisco's program took effect, the number of residents without health coverage has been reduced from 82,000 to fewer than 23,000. Katz Dec. at ¶ 10. And as a direct result of the employer spending requirement, more than 37,000 workers now have health coverage from the [16] City's program. *Id.* at ¶ 11.[9] A substantial percentage of those enrolled in the program are receiving essential preventive and diagnostic care for chronic conditions such as asthma, heart disease, diabetes, hypertension or cancer. In all, the HAP has so far provided 73,414 health visits, filled 83,200 prescriptions for medication, and performed 2,350 surgical procedures. 41% of those health visits were for conditions that, if left untreated, would lead to heart disease. Another 45% were for conditions that, if left untreated, would lead

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[9] This does not even account for the thousands of workers whose employers chose to provide coverage themselves rather than complying through the city payment option. The City has not yet collected data on this point.

to hospital-based emergency department overuse. *Id.* at ¶¶ 12-14. In short, San Francisco is well on its way to resolving its health care crisis.

GGRA's application seeks to force San Francisco back into the old, failed paradigm for health care delivery that the City and its health officials have worked so hard to escape. Most immediately, elimination of the employer spending requirement would deprive these 37,000 workers of their existing health coverage through San Francisco's program. *Id.* at ¶ 15. This loss of coverage would likely cause substantial numbers of these individuals to cancel planned medical visits and surgeries, forego ongoing medical treatment and prescription medicine, and otherwise take health risks that will result in major declines in health and unnecessary hospitalizations. *Id.* And it has been firmly established that when people lose their health coverage, they receive less care, they are likely to experience major declines in health, and are more likely to be hospitalized. *Id.* Particularly given that many HAP participants have chronic conditions that require regular treatment and monitoring in order to avoid significant [17] health risks and complications, serious human suffering would result if the stay were granted.

To cite an example the Director of Public Health provides to illustrate the importance of the program, one former restaurant worker with a chronic heart condition, mitral valve prolapse, was unable to obtain health insurance. She needed surgery for her condition, which would have cost her more than $100,000

if performed at a private facility, rendering it unaffordable for her. Because this person was able to join the HAP, she obtained the surgery, and believes she might not still be alive today if she had been unable to obtain this service from the City's new program. *Id.* at ¶ 16.

GGRA misleadingly suggests none of this matters because San Francisco "already has an obligation," under state law, "to provide health services to its residents." App. at 27. What California law actually states is that counties must provide health services to "indigent" residents. Cal. Welf. & Inst. Code § 17000. Residents who qualify for indigent health care services are deemed "insured" for purposes of this measurement, and therefore the residents who qualify as "indigent" for purposes of this code section were not part of the group of 82,000 uninsured residents that existed before the ordinance became operative. CCSF Appendix B at 4. Accordingly, this state law provision will do nothing to diminish the adverse consequences of a stay for San Francisco and its residents.

The association also suggests that even if the 37,000 workers lost their existing health coverage, the harm they would suffer is speculative because, should they encounter health problems, they might still seek emergency care at San Francisco General Hospital. App. at 28. But reliance on public hospital emergency rooms to provide care to the [18] uninsured is the very embodiment of the health care crisis the ordinance seeks to address (and that is now a

subject of national debate, as discussed *infra*). As the brief of the California Medical Association demonstrated below, a system that relies on use of emergency rooms by the uninsured imposes a tremendous financial strain on local governments, prevents emergency rooms from actually saving lives in true medical emergencies, and deprives the uninsured of the preventive care, diagnostic care, and the monitoring they need to avoid emergencies in the first place. CCSF Appendix, Ex. C at 8-12. Following enactment of the ordinance, emergency room visits to San Francisco General Hospital went down almost *seventy percent* – from 29,976 in the second quarter of 2007 to 8,944 in the second quarter of 2008. *Id.* at 5. GGRA's suggestion that there would be no harm in returning to the old way of dealing with the health care crisis is, to put it charitably, crass.

Even beyond the 37,000 workers who are currently covered, shutting down the health care spending requirement could destroy the City's health care program altogether. If the City were to offer comprehensive health care to its residents without an employer spending requirement, there would be tremendous incentive for employers that currently provide health insurance to their workers to drop that coverage, on the assumption that the workers will simply be absorbed into the HAP. Indeed, workers themselves might prefer that their employer-based coverage be dropped in exchange for a wage increase, given the availability of comprehensive health coverage from the HAP. The impact of this

shift could be tremendous – it bears repeating that, prior to enactment of the ordinance, roughly 90% of medium and large employers already provided health insurance to their employees. If even a meaningful portion of those [19] workers were foisted onto the City's program, the strain on the HAP may be too great to bear. Katz Decl. at ¶ 18. The City, in this time of budget shortfalls, cannot realistically be expected to invest the even greater amounts of public dollars that would be necessary to achieve universal health care in the face of widespread cancellation of employer-based health plans, not to mention the loss of tens of millions of dollars in annual revenue the HAP receives from employer payments. *Id.* at ¶ 11.

Finally, the equities tip sharply on the side of the City because it has invested a tremendous amount of money and time to bring the employer spending requirement into operation, all of which would have to be repeated if the requested stay was entered and the law was subsequently upheld. Over the past year, the City has invested hundreds of thousands of dollars on a widespread educational campaign to inform employers of the ordinance and educate them about their compliance options. Katz Decl. at ¶ 7. And it has spent millions of dollars to create enrollment systems and other tools to ensure that employers and their workers would readily benefit from the coverage under the City's program. *Id.* at ¶ 9. If the health care spending requirement were to be shut down, only to resume again a year later (after favorable ruling by this Court or, say, an act of Congress that explicitly

authorized the program while the case is still pending), much of this time and expenditure would have been wasted, and would have to be repeated. *Id.* at ¶ 8.

In short, the hardship alleged by GGRA pales in comparison to the harm the City and its residents would suffer should GGRA succeed in its effort to obtain a stay.

[20] **III. THE CASE IS NOT WORTHY OF CERTIORARI.**

A. The Decision Below Does Not Create A Split With The Fourth Circuit.

The circuits are in agreement that "[w]here a legal requirement may be easily satisfied through means unconnected to ERISA plans, and only relates to ERISA plans at the election of an employer, it affects employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." *Keystone Chapter, Associated Builders & Contractors v. Foley*, 37 F.3d 945, 960 (3d Cir. 1994) (internal quotations, citations and brackets omitted). *See also Fielder*, 475 F.3d at 193; *Hattem v. Schwarzenegger*, 449 F.3d 423, 429 (2d Cir. 2006); *S. Cal. IBEW-NECA Trust Funds v. Standard Industrial Elec. Co.*, 247 F.3d 920, 925 (9th Cir. 2001); *WSB Elec. Inc. v. Curry*, 88 F.3d 788, 795 (1996).

This agreed-upon rule is based on this Court's authority, which establishes that local laws which *influence choices* relating to ERISA plans are not

preempted unless the influence on an employer's choice is so great that it amounts to a *substantive mandate* regarding an ERISA plan. *See Travelers Ins.*, 514 U.S. at 664 ("Although even in the absence of mandated coverage there might be a point at which an exorbitant tax leaving consumers with a Hobson's choice would be treated as imposing a substantive mandate, no showing has been made here that the surcharges are so prohibitive as to force all health insurance consumers to contract with the Blues"); *see also Cal. Div. of Labor Stds. Enforcement v. Dillingham Constr., N.A.*, 519 U.S. 316, 332-33 (1997).

Far from creating a split, the decisions of the Fourth Circuit in *Fielder* and the Ninth Circuit in this case, taken together, do nothing more than apply these well-established principles in the context of health care spending. As the Fourth Circuit explained, the spending requirement at [21] issue in *Fielder* was preempted because it imposed a penalty that forced the employer to alter its ERISA health care plan, while, as the Ninth Circuit explained, San Francisco's ordinance is not preempted because it creates a comprehensive government health care program into which employers may pay on behalf of their workers, thereby providing them with a reasonable compliance option that does not involve the alteration of an existing ERISA plan or the creation of a new plan.

Specifically, *Fielder* involved a preemption challenge to Maryland's Fair Share Act, which

provided that any Maryland for-profit employer with more than 10,000 employees that does not spend up to 8% of its payroll on health insurance (*i.e.*, Wal-Mart) must make up the deficiency by paying it to the Secretary of Labor. *Id.* at 184. The Secretary of Labor was authorized to use the proceeds of any payments by Wal-Mart to fund Maryland's Medicaid program. *Id.* Wal-Mart's employees would not receive any additional benefits, services, or cost savings in return for such payments. *Id.* at 193.

Recognizing that a law which "effectively mandates some element of the structure or administration of employers' ERISA plans" is preempted while a law that "do[es] not bind the choices of employers or their ERISA plans" is generally permissible, the Fourth Circuit concluded that the Fair Share Act fell within the former category and was thus invalid. *Id.* at 193. The Court reasoned that the Maryland law effectively required Wal-Mart to alter its ERISA plan because no rational employer would choose to pay this money to the State when it could instead increase health care spending in a manner that benefited its employees:

> In effect, the only rational choice employers have under the Fair Share Act is to structure their ERISA healthcare benefit plans so as to meet the minimum spending threshold. The Act thus falls squarely under [22] *Shaw*'s prohibition of state mandates on how employers structure their ERISA plans.

Id. at 193-194.

As the Ninth Circuit explained, San Francisco's ordinance, "[i]n stark contrast to the Maryland law, . . . offers employers a meaningful alternative that allows them to preserve the existing structure of their ERISA plans." *GGRA II*, 546 F.3d at 660. Employees whose employers comply through payments to the City, rather than by establishing or altering ERISA plans, receive "tangible benefits" in return. *Id.*

Highlighting the reasonableness of this choice as compared to the penalty in Maryland, 894 employers have selected the city payment option since the health care spending obligation took effect. Katz Decl. at ¶ 11. That so many employers have selected the city payment option is not surprising, since it allows employers to avoid the inconvenience of setting up their own ERISA plans, while ensuring that their workers will receive comprehensive health coverage from the City at a price far lower than it would cost in the private market.[10]

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[10] Specifically, by simply writing a check to the City, employers avoid a burden that may include hiring an employee benefits consultant, learning about and deciding among the many benefit options, contracting with a third party administrator to maintain the plan and process employee claims, preparing the disclosure documentation required by ERISA, complying with ERISA's reporting requirements, and potentially exposing themselves to ERISA-related litigation. And the health benefits received by employees from the City will often be extraordinarily generous in relation to the amount paid by the employer. As discussed at pp. 7-9, *supra*, the average insurance premium in California $379 per month when the ordinance took effect. In contrast, for a medium sized employer with an

(Continued on following page)

[23] Notwithstanding this, GGRA claims an inter-circuit conflict based on the Fourth Circuit's discussion of an issue that was not presented to, or considered by, the Ninth Circuit here. Specifically, after holding that the option of paying the government was nothing more than a penalty that forced Wal-Mart to alter its ERISA plan, the court went on to address Maryland's alternative argument that Wal-Mart had other, private non-ERISA means for complying. These alternatives, according to Maryland, were to satisfy the spending requirement through the creation and administration of on-site medical clinics, or through the establishment of Health Savings Accounts ("HSAs"). The court rejected this argument on the ground that the purported alternatives were unrealistic. 475 F.3d at 196. And *then* the court observed that even if Wal-Mart could avail itself of these options, doing so would necessarily also produce a change in the company's ERISA plan:

> If Wal-Mart were to attempt to utilize non-ERISA health spending options to satisfy the Fair Share Act, it would need to coordinate

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employee who works 20 hours per week, the employer could satisfy its spending obligation in 2008 by paying the City $93.60 per month. This allowed the employee to obtain a membership that provides comprehensive health services, which cost the City on average $261 per month to provide. In other words, if the employer chooses the government payment option, its employees receive comprehensive health benefits for pennies on the dollar, and the City picks up the rest of the tab.

> those spending efforts with its existing ERISA plans. For example, an individual would be eligible to establish a Health Savings Account only if he is enrolled in a high deductible [ERISA] health plan. *See* 29 U.S.C. § 223(c)(1). In order for Wal-Mart to make widespread contributions to Health Savings Accounts, it would have to alter its package of ERISA health insurance plans to encourage its employees to enroll in one of its high deductible health plans. From the employer's perspective, the categories of ERISA and non-ERISA healthcare spending would not be isolated, unrelated costs. Decisions regarding one would affect the other and thereby violate ERISA's preemption provision.

Id. at 196-97. As Judge William Fletcher pointed out in his opinion concurring in the denial of rehearing en banc, GGRA and the dissenting judges omit the sentences from the above passage which show that the [24] Fourth Circuit was addressing Maryland's specific argument pertaining to on-site medical clinics and HSAs. GGRA Appendix, Ex. F.

Accordingly, the decisions of the Fourth and Ninth Circuits are not in conflict. Both decisions apply well-established precedent, and their holdings operate in harmony to reaffirm the general ERISA preemption principle – in the specific context of heath care – that while a local government may not effectively force employers to alter or adopt ERISA plans, it may impose spending obligations that allow

employers to comply while leaving ERISA plans undisturbed.[11]

B. Other Factors Counsel Against A Grant Of Certiorari.

Particularly given the absence of an inter-circuit conflict, even if the Court believes this ERISA preemption issue may someday be worthy of review, there are substantial reasons to avoid confronting the issue at this time, in the context of this case.

First, there is no serious possibility that other jurisdictions will adopt programs like San Francisco's in the near future. GGRA has cited only measures that were proposed prior to 2006; it does not cite one measure proposed after the Ninth Circuit allowed San Francisco's program to take effect. Furthermore, many of those pre-2006 proposals were similar or identical to the law struck down by the Fourth Circuit, *See* p. 15, supra. Under the Ninth Circuit's reasoning, proposals of this kind have not been given new life.

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[11] GGRA also contends this case is worthy of certiorari because the decision below conflicts with the decisions of this Court. Because, in reality, a ruling striking down San Francisco's program would require the Court to jettison its existing precedent, GGRA's contention in this regard is more appropriately addressed in Section IV, which explains why a majority of the Court would be unlikely to reverse the decision below.

[25] Moreover, it would be extraordinarily difficult for other jurisdictions to establish the type of reasonable non-ERISA compliance option provided by San Francisco's ordinance: payment into a comprehensive, government-run health care program that the City invested significant public dollars to build, and spends significant public dollars (substantially more than that received from employer payments) to maintain. Particularly in this time of financial hardship for state and local governments, it will be challenging indeed to follow in San Francisco's footsteps.

Of course, if that turns out wrong, and if GGRA's dire forecast of multiple health care obligations across jurisdictions bears out, then the Court will have ample opportunity to address the matter in the future. But because there is no reason to credit GGRA's assertion that multiple laws are on the verge of sprouting up, and because GGRA's contention that compliance with multiple spending requirements will be unworkable for employers is presently based on pure speculation, intervention by the Court is not required at this time.

On a related note, the national discussion on President Obama's proposal for health care reform is beginning in earnest, and there are reasons for the Court to avoid venturing into that discussion. Generally speaking, the enactment of national heath care legislation could obviate the need for local governments to act separately to address the health care crisis – indeed, this is presumably another

reason other jurisdictions are not rushing to build programs of the HAP's magnitude. And if the federal government enacts legislation that includes an employer spending requirement as the President has proposed, this would presumably preempt local requirements like San Francisco's. Or, national health care reform may take another route, by explicitly authorizing local requirements like [26] San Francisco's. Either way, the outcome of the health care debate could very well moot the ERISA preemption issue GGRA urges the Court to take up immediately.

IV. THE DECISION BELOW IS CORRECT.

Finally, even if the Court were to grant certiorari, it would likely affirm the decision below. GGRA's argument on the merits is that local governments may not subject employers to health care expenditure requirements. This argument rests on the assumption that when it comes to matters (like health care) that are mentioned in ERISA, local governments simply may not impose expenditure requirements. This Court has rejected that assumption. Indeed, the Court would be required to repudiate the principles expressed in its existing ERISA preemption cases to rule in GGRA's favor.

Although ERISA's preemption provision protects employers' ability to maintain *plan* uniformity, it does not guarantee *expenditure* uniformity for employers. For example, in *Fort Halifax,* the Court held that a

state law requiring minimum severance pay expenditures was not preempted because it did not interfere with plan uniformity. The Court made clear that states and localities may regulate the benefits mentioned in ERISA so long as they do not require alteration of ERISA plans:

> Appellant's basic argument is that any state law pertaining to a type of employee benefit listed in ERISA necessarily regulates an employee benefit plan, and therefore must be pre-empted. Because severance benefits are included in ERISA, *see* 29 U.S.C. § 1002(1)(B), appellant argues that ERISA pre-empts the Maine statute. In effect, appellant argues that ERISA forecloses virtually all state legislation regarding employee benefits. This contention fails, however, in light of the plain language of ERISA's pre-emption provision, the underlying purpose of that provision, and the overall objectives of ERISA itself. . . . ERISA's pre-emption provision does not refer to state laws relating to "employee benefits," but to state laws [27] relating to "employee benefit *plans*" . . . The words "benefit" and "plan" are used separately throughout ERISA, and nowhere in the statute are they treated as the equivalent of one another. Given the basic difference between a "benefit" and a "plan," Congress' choice of language is significant in its pre-emption of only the latter.

482 U.S. at 7-8 (emphasis in original).

Similarly, in *Morash,* the Court considered the preemptive effect of ERISA on state laws requiring the payment of unused vacation benefits to employees upon their discharge. Even though vacation pay is listed in ERISA, the Court concluded that such state laws are not preempted, so long as they do not infringe upon ERISA plans. 490 U.S. at 114-15.

In the area of health care itself, the very structure of ERISA necessarily contemplates that employers will be subject to disparate costs across jurisdictions. After all, ERISA's savings clause exempts from preemption state laws regulating insurance. 29 U.S.C. § 1144(b)(2)(A). This has resulted in the enactment of more than 1,961 mandates on health insurance, and no two states impose identical sets of coverage mandates. Victoria Craig Brunce et al., *Health Insurance Mandates in the States,* Council for Affordable Health Insurance (2008 ed.) at 1. Accordingly, the cost of employer-provided health insurance varies wildly from state to state. *Id.* at 3-5.

Congress never could have included the savings clause if it had viewed ERISA as preserving expenditure uniformity for employers in the area of health care. "Such disuniformities . . . are the inevitable result of the congressional decision to 'save' local insurance regulation." *Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. 724, 747 (1985). And that is why "*cost uniformity was almost certainly not an object of pre-emption*, just as laws with only an indirect economic effect on the relative [28] costs of various health insurance packages in a given State

are a far cry from those 'conflicting directives' from which Congress meant to insulate ERISA *plans*." *Travelers*, 514 U.S. at 662 (emphasis added).

The upshot is that employers commonly face differing cost (and recordkeeping) requirements in different jurisdictions. They are subject to varying severance pay requirements, minimum wage requirements, vacation pay requirements, apprenticeship and/or training program requirements, taxes, fees, and sick leave requirements, to name just a few. And a requirement in one of these areas may affect the employer's decision about expenditures in another area. Such is the unavoidable (and utterly unremarkable) consequence of doing business in multiple jurisdictions in the United States.

In sum, ERISA does not insulate businesses from being required to spend money. Local requirements are only preempted if they interfere with *plan* uniformity, and as discussed at length herein, San Francisco's ordinance does not do that. To reverse the decision below, the Court would be required to repudiate the principles discussed above, as well as the cases that articulate them, such as *Fort Halifax, Morash, Travelers,* and *Dillingham*. Accordingly, it is unlikely that five Justices of this Court would rule in GGRA's favor on the merits.

[29] **CONCLUSION**

The application for a stay should be denied.

Dated: March 27, 2009

Respectfully submitted,

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APPENDIX B

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[SEAL]

REGULATIONS IMPLEMENTING HEALTHY SAN FRANCISCO AND MEDICAL REIMBURSEMENT ACCOUNT PROVISIONS OF THE SAN FRANCISCO HEALTH CARE SECURITY ORDINANCE

1. Purpose

(a) The purpose of these Regulations is to implement Chapter 14, Sections 14.2 and 14.4 of the San Francisco Administrative Code, the San Francisco Health Care Security Ordinance ("HCSO" or "Ordinance") which authorizes the Department of Public Health ("DPH") to: (i) create and administer a program to provide health care services to San Francisco's uninsured residents; and (ii) establish and maintain Medical Reimbursement Accounts for non-residents who work in San Francisco and other qualified individuals.

(b) The program referenced in subsection (a)(i) above is identified in the Ordinance as the "Health Access Program." However, DPH has determined that the name "Health Access Program" creates confusion

among San Francisco residents because of its similarity to other programs. Accordingly, the program shall be named "Healthy San Francisco," and is hereinafter referred to in these regulations as "Healthy San Francisco."

(c) The Healthy San Francisco program will be among those programs offered in satisfaction of the City and County of San Francisco's obligation to provide services to indigent persons under California Welfare and Institutions Code Section 17000. The Regulations in no way shall be construed as an expansion of the City and County of San Francisco's existing obligations to provide health care under any California and/or federal law. Nor shall the regulations limit an individual's entitlement to those services otherwise required under California law.

2. Definitions

(a) *Applicant.* Any person who applies to participate in the Healthy San Francisco program or the Medical Reimbursement Account program.

(b) *Application.* The form developed by DPH to determine applicant eligibility for Healthy San Francisco.

(c) *City.* The City and County of San Francisco.

(d) *Clinical Site or Clinical Setting.* Any licensed facility that provides health services.

(e) *Covered Employee.* Any person that meets the definition provided in Section 14.1(b)(2) of the Administrative Code and Regulation 3 of the Office of Labor Standards and Enforcement's Regulations Implementing the Employer Spending Requirement of the San Francisco Health Care Security Ordinance.

(f) *Covered Employer.* An employer that meets the definition as set forth in Section 14.1(b)(3) and its inclusive subparts of the Administrative Code and Regulation 2 of the Office of Labor Standards and Enforcement's Regulations Implementing the Employer Spending Requirement of the San Francisco Health Care Security Ordinance.

(g) *Federal Poverty Level.* Level determined by the "Poverty Guidelines for the 48 Contiguous States and the District of Columbia" as contained in the *Annual Update of the HHS Poverty Guidelines* developed by the United States Department of Health and Human Services as published in the Federal Register.

(h) *Healthy San Francisco Participant.* Any uninsured San Francisco resident who fulfills all Healthy San Francisco eligibility provisions and is enrolled in the program.

(i) *Health Services.* Those services provided through the Healthy San Francisco program which a Participant will receive to treat a health or medical condition, promote health and/or prevent disease.

(j) *Household Income.* The total annual income of all family members in a household.

(k) *Medical Home.* The clinical site or clinical setting in which a Participant receives preventive and primary care services.

(l) *Medical Reimbursement Account.* An account established and maintained by DPH or its vendor from which eligible individuals may receive reimbursement for out-of-pocket medical expenses.

(m) *Ordinance.* The San Francisco Health Care Security Ordinance adopted by San Francisco Board of Supervisors as Ordinance 218-06, inclusive of any future and subsequent amendments.

(n) *Participation Fee:* A quarterly amount that Participants in Healthy San Francisco must pay to remain eligible for care under the program.

(o) *Point-of-Service Fees:* The amount(s) a Participant must pay for specific services at the time services are obtained.

(p) *Provider:* A California licensed health plan, hospital, clinic, medical group or clinician contracted to deliver health services to program Participants.

(q) *Third-Party Administrator.* A vendor or other entity that DPH enters into a contract with to perform specified administrative functions on behalf of the program.

3. Healthy San Francisco Program Eligibility

(a) An eligible Participant is any person who:

(i) resides in San Francisco and provides documentation of San Francisco residency based on the guidelines stated in the Healthy San Francisco program brochure provided to applicants;

(ii) is between the ages of 18 and 64 years old, or is an emancipated minor, or a minor not living in the home of a birth or adoptive parent, a legal guardian, caretaker relative, foster parent, or stepparent, and is applying for coverage on his or her own behalf;

(iii) has been without employer-based or individually-purchased health insurance for 90 days from the date of application for Healthy San Francisco eligibility, or has lost employer-based health care coverage within 90 days of date of application due to a change in employment status, or who has lost COBRA coverage within 90 days of date of application; and

(iv) is ineligible for California and/or federally-funded health insurance or assistance programs, provided that the applicant's eligibility for the following programs shall not make the applicant ineligible for Healthy San Francisco:

1) Pregnancy-Related Medi-Cal (Omnibus Budget Reconciliation Act);

2) Pregnancy-Related Medi-Cal (Presumptive Eligibility);

3) AIM Access for Infants and Mothers and

4) Omnibus Budget Reconciliation Act Medi-Cal (non-pregnancy and emergency only).

(b) Neither employment status, immigration status nor the existence of pre-existing health conditions shall be used to exclude a person from eligibility for Healthy San Francisco.

(c) DPH will develop an application for participation in Healthy San Francisco and a process for obtaining a Medical Reimbursement Account for potential participants.

(d) The Healthy San Francisco application will collect information from the applicant necessary to determine program eligibility and eligibility for any subsidies for participation in the program, including, but not limited to name, address, household income, and employment status.

(e) An eligible Participant shall be enrolled for participation into the Healthy San Francisco program if he/she submits a completed application, fulfills the eligibility requirements and pays the required participation fees as established by DPH.

(f) DPH shall, from time to time, require participants to re-establish eligibility for participation in Healthy San Francisco.

4. Healthy San Francisco Program Fees

(a) Healthy San Francisco will have two fee components for its Participants; "participation fees" and "point-of-service fees." These fees shall be based on Participant income which is measured with reference to the Federal Poverty Level.

(i) Participation fees shall be assessed on a quarterly basis for continued participation in the Healthy San Francisco program.

(ii) Point-of-service fees shall be assessed on a sliding scale based on a Participant's Federal Poverty Level when a Participant receives services at a clinical site or clinical setting.

(iii) Any person with an annual household income between 0% and 500% of the Federal Poverty Level shall be eligible for a subsidy for the participation fee, to be determined by DPH.

(b) Non-payment of the participation fee by the program Participant can result in cancellation of enrollment from the Healthy San Francisco program.

5. Healthy San Francisco Services

(a) The program shall provide health services for the treatment of medical conditions with an emphasis on wellness, preventive, and primary care. Services include: professional services by clinicians

(i.e., doctors, nurse practitioners, physician assistants, and other licensed health care providers) including preventive, primary, diagnostic, and specialty services; inpatient and outpatient hospital services; diagnostic and laboratory services, including therapeutic radiological services; behavioral health services, including mental health and substance abuse services; prescription drugs, excluding drugs for excluded services; home health care; urgent care; and emergency care provided in San Francisco.

(b) The following is a non-exclusive list of services that shall not be provided by Healthy San Francisco program:

(i) Acupuncture;

(ii) Allergy Testing and Injections;

(iii) Audiology (including hearing aids);

(iv) Chiropractic;

(v) Cosmetic;

(vi) Dental;

(vii) Gastric By-Pass Surgery and Services;

(viii) Genetic Testing and Counseling;

(ix) Infertility;

(x) Long-Term Care;

(xi) Organ Transplants;

(xii) Sexual Reassignment Surgery;

(xiii) Transportation: Non-emergency; and

(xiv) Vision.

(c) Healthy San Francisco does not include any services, including emergency services, provided outside the City and County of San Francisco.

6. Healthy San Francisco Service Provision and Delivery Network

(a) Each Participant shall have a designated clinical site or clinical setting that shall serve as his/her primary care medical home. The primary care medical home shall coordinate a Participant's access to services in the program, monitor management of medical conditions and provide continuity of care.

(i) Upon enrollment into the program, Participants shall select their primary care medical home from a list of participating Healthy San Francisco clinic sites or clinical settings.

(ii) Participants may request a medical home change during their pre-determined program recertification and re-enrollment process.

(iii) Participants may make requests to change their primary care provider (i.e., a physician, nurse practitioner or physician assistant) within their medical home.

(b) The network of providers delivering services to program Participants shall be confined to licensed providers who have a physical location and practice in the City and who have entered into agreements and/or contracts with DPH and/or its Third-Party Administrator to provide services under this program.

(c) Healthy San Francisco shall not include or reimburse payment for services delivered to program Participants by providers that have not entered into agreements and/or contracts with DPH and/or its Third-Party Administrator to provide services to Participants under this program.

7. Covered Employee Participation Rules

(a) Covered Employers who chose to satisfy the Employer Spending Requirement under the Ordinance by making payments to the City shall deliver the payments to DPH's Third Party Administrator. Payments shall be made consistent with the provisions of Section 14.3(a) of the Administrative Code and Regulation 6 of the Office of Labor Standards and Enforcement's Regulations Implementing the Employer Spending Requirement of the San Francisco Health Care Security Ordinance.

(b) Along with its payments, the Covered Employer shall provide to DPH's Third-Party Administrator: (i) the name of the Covered Employee, (ii) the amount paid per Covered Employee and (iii) other information as needed by DPH to determine whether the Covered Employee is eligible for participation in

Healthy San Francisco or for the establishment of a Medical Reimbursement Account. DPH or its Third-Party Administrator shall provide Covered Employers with a form upon which they may provide this information along with their payments.

(c) DPH's Third-Party Administrator will use the information provided by the Covered Employer pursuant to subsection 7(b) above to determine whether the payment made on behalf of a Covered Employee shall be used to fund the Covered Employee's participation in Healthy San Francisco or to establish a Medical Reimbursement Account for the Covered Employee.

(d) Covered Employees on whose behalf a payment has been made to satisfy the Employer Spending Requirement shall be notified by their Covered Employer that such a payment has been made in accordance with Regulation 7.1 of the Office of Labor Standards and Enforcement's Regulations Implementing the Employer Spending Requirement of the San Francisco Health Care Security Ordinance.

(e) DPH or its Third-Party Administrator shall inform Covered Employees where they may go to be screened for enrollment in Healthy San Francisco and/or establishment of Medical Reimbursement Accounts.

(f) A Covered Employee on whose behalf payment has been made to DPH must, in order to participate in Healthy San Francisco, meet program

eligibility requirements and enroll in Healthy San Francisco.

(i) A Covered Employee who is determined to be eligible for Healthy San Francisco shall receive a discount of 75% off the participation fee that s/he would otherwise be required to pay to participate in Healthy San Francisco. If as a result of the discount the fee is less than $50 per quarter, the participation fee shall be waived.

(ii) Payments by the Covered Employer shall entitle the Covered Employee to a discounted Participation Fee for six months from the date of enrollment. After six months from the date of enrollment, and every six months thereafter, DPH or its Third-Party Administrator shall determine whether the Participant's Covered Employer has continued payments on the Participant's behalf in the preceding six months. If the Covered Employer has continued to make such payments, the Participant shall remain eligible for a discounted Participation Fee for the following six months. If DPH or its Third-Party Administrator determines that the Covered Employer has not made payments on the Participant's behalf for the preceding six months, the Participant may remain enrolled in Healthy San Francisco by paying a non-discounted Participation Fee.

(g) A Covered Employee that does not meet the program eligibility requirements for participation in Healthy San Francisco but wishes to benefit from the payment made on his/her behalf by a Covered Employer, may sign up for a Medical Reimbursement Account to be established and maintained by DPH's Third Party Administrator. Any funds collected on behalf of a Covered Employee during the calendar year shall be forfeited if the Covered Employee does not sign up for a Medical Reimbursement Account by July 1 of the subsequent calendar year. Any forfeited funds shall be used by DPH to fund the programs described in these regulations.

(i) Covered Employees may obtain reimbursement from the Medical Reimbursement Account for medical care, services or goods that may qualify as tax deductible medical expenses under Section 213 of the Internal Revenue Code including the costs of diagnosis, cure, mitigation, treatment, or prevention of disease, and the costs for treatments affecting any part or function of the body, including the costs of equipment, supplies and diagnostic devices needed for these purposes. Reimbursable medical expenses may also include dental expenses, premiums paid for insurance that covers the expenses of medical care and the amount paid for transportation to receive medical care.

(ii) Any administrative fees charged to the City to establish and maintain the Covered Employee's Medical Reimbursement Account shall be deducted from the balance amount in that Covered Employee's Medical Reimbursement Account.

(iii) A Covered Employee must use the money deposited into the Medical Reimbursement Account within a designated period of time as determined by DPH.

8. Public Information on Healthy San Francisco

(a) DPH shall make available to the public all information necessary to facilitate participation in the programs authorized by the Ordinance.

(b) Written program materials for applicants and participants will be offered, at a minimum in the following languages: Chinese, English and Spanish.

(c) DPH will maintain a program website and ensure that access to program information is available through the 311 System operated by the City.

9. Healthy San Francisco Administration

(a) DPH is responsible for the overall administration of the Healthy San Francisco and Medical Reimbursement Account programs. Its responsibilities include, but are not limited to: overseeing overall

program development and implementation; defining program goals, design and policy objectives; ensuring adequate financing and evaluating the program's effectiveness.

(b) DPH may enter into a vendor/contract relationship with a Third-Party Administrator and/or other entities to perform specific administrative or programmatic functions needed to appropriately operate and maintain the program.

10. Reporting

(a) DPH shall make annual reports to the San Francisco Health Commission on the status of the Healthy San Francisco and Medical Reimbursement Account programs.

(b) DPH shall comply with Section 14.4(f) of the Administrative Code with respect to Healthy San Francisco and Medical Reimbursement Account program reports to the San Francisco Board of Supervisors.

APPENDIX C

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

GOLDEN GATE RESTAURANT ASSOCIATION, an incorporated non-profit trade association,

Plaintiff,

v.

CITY AND COUNTY OF SAN FRANCISCO and Does 1 through 15, inclusive,

Defendants,

and

SAN FRANCISCO CENTRAL LABOR COUNCIL, SERVICE EMPLOYEES INTERNATIONAL UNION ("SEIU") LOCAL 1021, SEIU UNITED HEALTHCARE WORKERS – WEST, and UNITE-HERE!, LOCAL 2,

Intervenors.

Case No. C06-6997 JSW

SAN FRANCISCO'S MEMORANDUM IN OPPOSITION TO GGRA'S MOTION FOR SUMMARY JUDGMENT

Hearing
Date: August 31, 2007
Time: 9:00 a.m.
Place: Courtroom 2
17th Floor

(Filed Aug. 3, 2007)

* * *

[9] GGRA appears to contend that any time a state or local government requires an employer to keep records of its health care expenditures, this runs afoul of ERISA. *See* GGRA's Memorandum of Points

and Authorities ("GGRA's Opening Brief") at 15-16. For this proposition GGRA cites *Aloha Airlines, Inc. v. Ahue,* 12 F.3d 1498, 1505 (9th Cir. 1993), in which the Ninth Circuit struck down a law that imposed reporting requirements on *a plan.* But again, GGRA fails to recognize that there is a distinction between imposing recordkeeping requirements on *an employer,* which is what the HCSO does, and imposing recordkeeping requirements on *an ERISA plan.* As the Ninth Circuit explained in *WSB* (a case not cited by GGRA in its opening brief), this distinction is significant. Although California's prevailing wage law required employers to keep track of benefit expenditures for employees on an hourly basis, this was an *employer payroll practice,* not a matter of ERISA plan administration. Because the recordkeeping requirements were imposed on employers, the law was not preempted. *WSB,* 88 F.3d at 793.[4]

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[4] An example of the distinction between employer payroll practices and ERISA plan administration practices is provided by GGRA itself. GGRA offers information about the plans offered by Max's Restaurants for the purpose of establishing standing. *See generally* Declaration of Gregory Boro in Support of GGRA's Motion for Summary Judgment. Although the City does not contest GGRA's standing, Max's plan documents provide an illustration of how the recordkeeping provisions of the Ordinance operate without interfering with uniform plan administration.

Max's provides health benefits to some of its employees through Kaiser and HealthNet HMOs. *See* Declaration of Vince Chhabria in Opposition to GGRA's Motion for Summary Judgment ("Chhabria Decl."), Exh. A-B. As the documents for

(Continued on following page)

Furthermore, the employer is already in possession of the minimal information necessary to establish compliance. As discussed above, the employer need only determine: (1) the hours worked by its covered employees; and (2) how much it spent on those employees. With respect to the first [10] item, numerous laws already require the employer to track hours worked, including California Labor Code section 226. Moreover, employers must already maintain records of hours worked by their San Francisco employees, as set forth in the City's Sick Leave Ordinance. *See* S.F. Admin. Code § 12W.6.[5] With respect to the second item, tracking the information

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those plans demonstrate, Max's has delegated virtually all aspects of plan administration to the HMOs themselves. The HMOs create the plan documents, process enrollment requests, create procedures for patients to file claims for benefits, and administer those claims procedures. *See, e.g.*, Chhabria Decl. Exh. A at 21, 30, 36, 42-43, 120-22, 133; Exh. B at 13, 17, 29, 40, 65-66, 72, 77-79. But the HCSO does not require the HMOs to keep records of any of these functions. Rather, it requires "covered employer[s]" to maintain records sufficient to demonstrate compliance with the Ordinance and to provide an annual report to the City. S.F. Admin. Code § 14.3(b). As even Mr. Boro admits in his declaration, it is "the company," not the HMOs, that will prepare the records necessary to establish compliance with the Ordinance. Boro Decl. at ¶ 8.

In any event, as demonstrated by the prevailing wage cases, even if an employer administers its own plan, laws like the HCSO impose recordkeeping obligations on the employer *qua* employer, not the employer *qua* plan administrator.

[5] As the documents submitted by Max's Restaurants demonstrate, it already keeps track of hours worked. *See* Chhabria Decl., Exh. C.

is even easier. For example, Max's Restaurants receives a bill every month from the HMOs which sets forth the amount due for *each individual employee.* Chhabria Decl., Exhs. D-E. With these two items of information, the employer need only divide item two by item one – i.e., the amount spent on health care for an employee by the number of hours worked by that employee – to establish compliance.[6]

In sum, employers commonly must engage in different payroll practices in different jurisdictions. As the prevailing wage cases already demonstrate, sometimes those payroll practices relate to health benefits. And in San Francisco, with the enactment of the HCSO, one of those payroll practices is the simple act of division described above. The Ordinance does not require ERISA plans to keep any records, nor does it require ERISA plans to report any information to the City. It requires employers to do so, and the

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[6] In fact, for employers that provide uniform health benefits to groups of employees, establishing compliance will be even easier than the simple calculation described above. Those employers can simply divide their total employee health care expenditures by the total number of hours their covered employees have worked, and if that calculation demonstrates that the employer is spending, on average, more than the minimum required amount per employee, compliance has been established. RJN Exh. B (OLSE Reg. No. 6.2(B)(1)). Based on Max's own description of its ERISA plans, *see* Boro Decl. at ¶¶ 5-7, it appears Max's could avail itself of this shortcut.

Ninth Circuit has made clear that this creates no preemption problem.[7]

C. The Enforcement Provisions Do Not Interfere With Uniform Plan Administration.

GGRA also contends the IICSO is preempted because it creates "an enforcement scheme beyond that provided by ERISA." GGRA Opening Brief at 16. Specifically, GGRA asserts that the provisions of the Ordinance that permit the Office of Labor Standards Enforcement ("OLSE") to

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[7] Furthermore, as discussed in the City's Opening Brief, even if the Ordinance were to impose these administrative burdens on ERISA plans as opposed to employers, the Supreme Court has upheld laws of general applicability that impose administrative burdens far more onerous than this one on ERISA plans. City's Opening Brief at 23; *Mackey v. Lanier Collection Agency & Service*, 486 U.S. 825, 831 (1988).

APPENDIX D

Amendment of the whole
in committee. 7/17/06

FILE NO. 051919 ORDINANCE NO. 218-06

[San Francisco Health Care Security Ordinance]

Ordinance amending the San Francisco Administrative Code to add Chapter 14, Sections 14.1 through 14.8, to provide health care security for San Francisco residents by creating a public health access program for the uninsured, requiring employer paid health expenditures, identifying options for how an employer may make such expenditures, creating an advisory health access working group, and setting an operative date.

Note: Additions are *single-underline italics Times New Raman*;
deletions are ~~*strikethrough italics Times New Roman*~~.
Board amendment additions are double underlined.
Board amendment deletions are ~~strike-through normal~~.

Be it ordained by the People of the City and County of San Francisco;

Section 1. **Declaration of legislative findings and intent.** All San Francisco residents should have quality, affordable health care. Currently, approximately 82,000 adult San Francisco residents are uninsured, even though more than half of those

individuals are employed. San Francisco taxpayers bear the cost of paying for emergency room visits and other unnecessarily expensive health care for the uninsured. By establishing a Health Access Program for uninsured San Francisco residents with an emphasis on preventive care and by requiring businesses' to make reasonable health care expenditures on behalf of their employees depending on the businesses ability to pay, the burden on San Francisco taxpayers for providing health care for the uninsured can be reduced. At the same time, San Francisco can offer uninsured individuals the choice to enroll in a system that provides quality health care for an affordable price and offer employers the choice to enroll their employees in that system. San Francisco also has a vital interest in preventing a "race to the bottom" in which employers stop paying for employee health care to remain competitive and instead shift those costs to San Francisco taxpayers.

* * *

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No. 08-1515

IN THE

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Petitioner,

v.

CITY AND COUNTY OF SAN FRANCISCO,
Respondent,

SAN FRANCISCO CENTRAL LABOR COUNCIL, *et al.*,
Intervenors/Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

SUPPLEMENTAL BRIEF FOR PETITIONER

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QUESTION PRESENTED

Whether ERISA section 514(a), 29 U.S.C. § 1144(a), preempts local laws mandating ongoing employer contributions for employee health benefits, or alternative payments to a local government, and extensive recordkeeping and reporting and disclosure requirements, a question on which the courts of appeals are in conflict.

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On Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

SUPPLEMENTAL BRIEF OF PETITIONER

In accordance with Supreme Court Rule 15.8, Petitioner respectfully submits this Supplemental Brief to bring to the Court's attention new legislation – the Patient Protection and Affordable Care Act, signed into law on March 23, 2010[1] and amended on March 30, 2010[2] (the "PPACA") – that undermines one of the grounds on which Respondent opposes the Petition.

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[1] Pub. L. No. 111-148, 124 Stat. 119.

[2] Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

We also alert the Court to the fact that its reasoning last month in *Conkright v. Frommert,* 130 S. Ct. 1640 (2010), applies with equal force to this case and implicitly rejects Respondent's position that the Ordinance can be harmonized with this Court's ERISA preemption cases.

I. THE FINAL FORM OF FEDERAL HEALTH CARE LEGISLATION UNDERMINES, IN PART, RESPONDENT'S OPPOSITION TO THE PETITION.

Respondent's Opposition Brief argues that "the serious possibility that federal legislation will moot the ERISA preemption issue in this case weighs heavily against the Court granting certiorari now." Opposition at 10; *see also id.* at 39 ("[T]he question presented by the petition may be mooted by national health care reform, so granting certiorari would not be a good use of the Court's resources."). According to Respondent, because federal legislation "would include a national employer mandate . . . it would be that new law, not ERISA, that preempts the City's health care spending requirement." *Id.* The PPACA, however, proves otherwise.[3]

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[3] The Mayor and Director of the Department of Health of San Francisco apparently no longer agree that the city's health care ordinance is rendered moot by the new federal law. Twice since Respondent filed its opposition brief, one or both of these top city officials have publicly stated that federal health care reform legislation would not render superfluous San Francisco's health care program created by the Ordinance. *See* Heather Knight, *Healthy San Francisco Expected To Continue,* S.F. Chron., Mar. 23, 2010, *available at* http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2010/03/23/MN4V1CJO00.DTL ("When San Francisco launched its first-of-its-kind universal health care program in the summer of 2007, city officials said they hoped

Set forth in ten titles across 906 pages, the PPACA unquestionably is large and, in places, complex. But as relevant to the question presented in this case, the new law is straightforward. Title I of the PPACA contains the provisions that bear directly on the PPACA mootness issue raised by Respondent.[4] Within title I, the new law does two things that matter: (1) it enacts a new employer mandate in the form of an excise tax, which has little preemptive force, and (2) it amends ERISA (by adding new minimum federal standards for health care coverage) without altering existing ERISA preemption rules. It additionally

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the program would someday be irrelevant because the federal government would provide health care for all. But on Monday, Mayor Gavin Newsome and Public Health Chief Mitch Katz said they are dedicated to ensuring the viability of Healthy San Francisco because major holes in the national plan, if signed into law, will leave out thousands of local residents."); Victoria Colliver, *National Plan Wouldn't Mean End of Healthy S.F.*, S.F. Chron., Nov. 23, 2009, *available at* http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2009/11/23/MNC31ALDNM.DTL ("'Since there are all these versions of these bills, none of which have passed, it's hard to say anything other than I know Healthy San Francisco is still going to be needed,' said Dr. Mitch Katz, director of the San Francisco Department of Public Health.").

[4] Some of the relevant provisions of title I of the PPACA were modified in title X of the PPACA (by section 10101). To spare readers the burden of flipping between different titles and between Public Law Nos. 111-148 and 111-152 merely to ascertain the final text of given provisions, the House Office of the Legislative Counsel created a document that consolidates and integrates into a single text all of the original and amending provisions of Public Law Nos. 111-148 and 111-152. It is available at http://www.ncsl.org/documents/health/ppaca-consolidated.pdf. That document allows readers of title I, for example, to see the provisions of that title, as modified by title X (and by Public Law No. 111-152), in their final and fully revised form in one place.

fails to do something at least as important: it does not exempt state and local "play or pay" laws from ERISA preemption. Because the PPACA neither preempts state and local "play or pay" laws nor exempts them from ERISA's preemption regime, its net effect is to leave the question presented in this case intact and still in urgent need of decision by this Court.

The Mandate. The PPACA's employer mandate does not preempt the San Francisco Ordinance. Congress wrote the federal mandate in the form of a new excise tax on "large employers" (those with 50 or more employees) that do not provide minimum health care coverage to employees. *See* PPACA § 1513 (adding new 26 U.S.C. § 4980H).[5] Under the PPACA, this tax preempts only those state laws that would "prevent [its] application." *See* PPACA § 1321(d) ("NO INTERFERENCE WITH STATE REGULATORY AUTHORITY.– Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title."). The San Francisco Ordinance's mandate, for all its fatal defects under ERISA (as discussed in the Petition and Reply), does not contradict, or "prevent the application of," the PPACA's new federal employer mandate, and therefore is not preempted by it.

Other state laws, by contrast, appear to contradict the new PPACA mandate and, to the extent they do so, are preempted by it. For example, a proposed amendment to Arizona's state constitution appears

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[5] Citations to the new law in this brief are in the form of "PPACA § __," based on the consolidated legislative text set forth in the document created by the House Office of the Legislative Counsel discussed in note 4, *supra*.

aimed squarely at the PPACA's employer mandate and its parallel individual mandate.[6] The proposed Arizona amendment provides that "[a] law or rule shall not compel, directly or indirectly, any person, employer or health care provider to participate in any health care system," and that a "person or employer may pay directly for lawful health care services and shall not be required to pay penalties or fines for paying directly for lawful health care services." H. Con. Res. 2014, 49th Leg., 1st Reg. Sess. (Ariz. 2009) (as transmitted to the Ariz. Secretary of State on July 7, 2009, and to be submitted to voters at the next general election as provided by Ariz. Const. art. XXI). If adopted, this state law, by all appearances, would directly obstruct the new mandates and, to that extent, be preempted by PPACA § 1321(d).

Virginia passed a similar law on March 10, 2010, apparently calculated to defeat the PPACA's individual mandate within the state. The Virginia law provides that "[n]o resident . . . shall be required to obtain or maintain a policy of individual coverage" and that "[n]o provision of this title shall render a resident . . . liable for any penalty, assessment, fee, or fine as a result of his failure to procure or obtain health insurance coverage." Va. Code Ann. § 38.2-3430.1:1 (2010). If given effect, the Virginia and Arizona provisions would appear to thwart the PPACA's employer and individual mandates, and thus fall within section 1321(d)'s sights.

State and local laws running the other way, like San Francisco's employer contribution requirement,

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[6] Congress included a new excise tax on individuals who fail to maintain "minimum essential coverage." *See* PPACA § 1501(b) (adding new 26 U.S.C. § 5000A).

which do not authorize that which the PPACA prohibits or prohibit that which the PPACA authorizes, do not "prevent the application" of the PPACA and therefore are not preempted by it.[7]

Minimum Standards. The PPACA's amendment of ERISA to add new minimum federal coverage standards for group health plans further undermines Respondent's argument that adoption of federal health reform would "weigh[] heavily" against granting the Petition.

The PPACA codifies new minimum coverage standards (which include such things as a prohibition against imposing annual or lifetime coverage limits and a requirement that preventive health services be covered without cost-sharing requirements) in two places. It first adds them to title XXVII of the Public Health Service Act ("PHSA"). *See* PPACA § 1001 (adding and amending various provisions of title XXVII of PHSA); *see also* 42 U.S.C. §§ 300gg to 300gg-92 (setting forth title XXVII of PHSA). It then adds them to ERISA by enacting a new ERISA section 715 (29 U.S.C. § 1185d) that simply incorporates by reference the relevant PHSA provisions. *See* PPACA § 1562(e) (adding section 715 to ERISA) (to be codified at 29 U.S.C. § 1185d).[8]

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[7] *Cf. MMA Ins. Co. v. Blue Cross & Blue Shield of Kansas, Inc.*, 552 F. Supp. 2d 1250, 1255-57 (D. Kan. 2004) (interpreting Public Health Services Act provision that expressly preempts state health insurance laws to the extent they "prevent[] the application of a requirement of this part," and finding state law preempted where its application would authorize a party to do exactly that which PHSA prohibits).

[8] Because these new standards are codified in part 7 of subtitle B of title I of ERISA, they are governed by special ERISA preemption rules set forth in 29 U.S.C. § 1191. That section

The PPACA effects this amendment without altering ERISA's existing preemption rules. It neither exempts state or local "play or pay" laws from ERISA preemption, nor does it expressly provide for their preemption by ERISA. The PPACA, therefore, is neutral on ERISA preemption of state and local "play or pay" laws. Contrary to Respondent's position, that leaves ERISA preemption front and center in this case.

II. THE ERISA PRINCIPLES ON WHICH THIS COURT DECIDED *CONKRIGHT v. FROMMERT* LAST MONTH SUPPORT GRANTING THE PETITION.

Respondent separately opposes the Petition on the ground that the Ninth Circuit's decision in this case "is consistent with this Court's ERISA preemption rulings." Opposition Brief at 24. In support, Respondent argues that ERISA's goals of national uniformity in plan administration and predictability across jurisdictional lines of legal outcomes, two points the Petition emphasized strongly,[9] are not meaningfully impaired by benefit mandates like the Ordinance. Opposition Brief at 27-29. This Court's reasoning last month in another ERISA case, however, implicitly rejects Respondent's argument and echoes points made in the Petition.

In *Conkright v. Frommert,* the Court held that an employee benefit plan administrator with discretionary authority to interpret the plan does not lose

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modifies the ERISA preemption rule that ordinarily would apply to state insurance laws touching on minimum coverage standards but otherwise expressly makes ERISA's general preemption provision, 29 U.S.C. § 1144, applicable.

[9] *See, e.g.,* Petition at 22.

Firestone[10] deference when exercising that discretion because of a prior honest mistake in plan interpretation. Although the Court ordinarily would have relied on trust law principles to decide a case like *Conkright*, those principles proved unavailing. So the Court looked to "the guiding principles we have identified underlying ERISA" to decide the case. *Conkright*, 130 S. Ct. at 1648.

ERISA's guiding principles, the Court held, are uniformity in legal standards governing plans, predictability in plan liabilities, and efficiency in plan administration. *Id.* at 1648-51. In articulating these principles, the Court emphasized that Congress sought to encourage employers to create benefit plans and "'to create a system that is [not] so complex that administrative costs, or litigation expenses, unduly discourage employers from offering [ERISA] plans in the first place.'" *Id.* at 1649 (citation omitted). "*Firestone* deference serves the interest in uniformity," the Court held, by "helping avoid a patchwork of different interpretations of a plan, like the one here, that covers employees in different jurisdictions – a result that 'would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them.'" *Id.* (quoting *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987)).

This reasoning supports the Petition and undermines the Opposition. As we explained in the Petition, state and local laws like the Ordinance ultimately would drive the structuring of benefits in employer-sponsored plans and, in doing so, com-

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[10] *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989).

pletely undermine national uniformity in plan administration and confidence that plan provisions are legal from one jurisdiction to another. *E.g.*, Petition at 7, 22, 23-34 (citing among other cases *Egelhoff v. Egelhoff,* 532 U.S. 141, 148 (2001)).

Respondent disagrees with Petitioner's reading of *Egelhoff,* arguing that *Egelhoff* held that a Washington statute regulating entitlement to survivor benefits under ERISA plans was preempted only because the statute required plan administrators and sponsors to ignore their plans or amend them to conform to Washington law, and it was only to that extent that the state law was held to have interfered with ERISA uniformity. Opposition Brief at 28-29. But the Court in *Conkright* saw a broader principle of uniformity at work in *Egelhoff*: "Thus, failing to defer to the Plan Administrator here could well cause the Plan to be subject to different interpretations in California and New York. 'Uniformity is impossible, however, if plans are subject to different legal obligations in different states.'" *Conkright,* 130 S. Ct. at 1651 (quoting *Egelhoff,* 532 U.S. at 148). Under *Conkright*, the possibility that plans would be subject to different legal rules in different jurisdictions was enough to offend ERISA's uniformity principle.

Conkright thus implicitly rejects the City's position that the Ordinance does not offend core ERISA values of national uniformity and predictability of plan governance rules. It therefore affirms the urgent need for the Court to grant the Petition.

Respectfully submitted,

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PETITIONER'S REPLY TO SOLICITOR GENERAL'S BRIEF

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Whether ERISA section 514(a), 29 U.S.C. § 1144(a), preempts local laws mandating ongoing employer contributions for employee health benefits, or alternative payments to a local government, and extensive recordkeeping and reporting and disclosure requirements, a question on which the courts of appeals are in conflict.

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PETITIONER'S REPLY TO SOLICITOR GENERAL'S BRIEF

In accordance with Supreme Court Rule 15.8, Petitioner respectfully submits this Reply to the Solicitor General's Brief.

I. INTRODUCTION.

In the Ninth Circuit, the Department of Labor filed an amicus brief arguing, correctly, that this case raises "an important question" and that the employer mandate in San Francisco's Ordinance is completely preempted by ERISA because it requires employee

benefit structures or their administration and it interferes with uniform plan administration. Labor Secretary's Amicus Brief at 1, 8-9. After the panel upheld the Ordinance, the Department of Labor took a full month to consider the court's opinion, then filed a second amicus brief supporting Petitioner's request for a rehearing en banc and arguing, once again correctly, that this case raises "a recurring issue of exceptional importance," that the Ordinance is clearly preempted because it mandates employee benefit structures or their administration and interferes with uniform plan administration, and that the panel's decision conflicts with *Retail Industry Leaders Association v. Fielder*, 475 F.3d 180 (4th Cir. 2007), and with this Court's ERISA preemption cases. Labor Secretary's Brief in Support of Rehearing ("DOL Rehearing Brief") at 7, 14-17.

In the 19 months that have since passed, the government has had a change in administration and a change of heart, at least in part. In this Court, the Solicitor General and the Department of Labor now argue that the ERISA preemption question in this case is not very important and that the Circuit conflict may merely reflect "tension" between the Fourth and Ninth Circuits. Significantly, however, they do not reverse themselves on the underlying legal merits – they do not claim that the San Francisco Ordinance actually survives ERISA preemption.

They seek to justify their partial reversal by asserting that passage of the Patient Protection and Affordable Care Act,[1] as amended[2] (the "PPACA"),[3]

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[1] Pub. L. No. 111-148, 124 Stat. 119.

[2] Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

reduces the likelihood that state and local governments will adopt new employer spending requirements. But the only affirmative evidence bearing on this theory tends to refute it. San Francisco's Mayor and Department of Public Health Director have recently vowed to keep the City's health care program under the Ordinance intact because they say it is needed to fill "holes" in PPACA's coverage.

By reversing itself in part to now advocate that the Ninth Circuit's departure from ERISA preemption law be allowed to stand, the government unintentionally amplifies the need for clarification by this Court that ERISA preempts state and local mandates—regardless of whether the mandates are for benefits or contributions—and that local jurisdictions may not pass laws that balkanize the regulation of employee benefit plans. The Court therefore should grant the petition and decide the important question presented by this case.

II. THE PPACA DOES NOT COUNSEL AGAINST GRANTING THE PETITION.

The Solicitor General invokes Congress's recent passage of the PPACA to make a two-fold argument against granting the Petition.

First, the SG argues that because the PPACA "will almost certainly significantly increase health care coverage" in the United States, the new law "make[s] it much less likely that States and localities will

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[3] The House Office of the Legislative Counsel has created a consolidated document that integrates the original and amending provisions of Public Law Nos. 111-148 and 111-152 into a single text. *See* http://www.ncsl.org/documents/health/ppaca-consolidated.pdf.

choose to adopt their own health care programs." SG's Brief at 15. This according to the SG "reduces substantially the ongoing importance of the question whether ERISA preempts state and local health care programs like the [Ordinance]." *Id.* We respectfully disagree with the government on at least two levels.

At the most basic level, the government's position is undermined by the very party the government seeks to support. Twice since Respondent filed its opposition brief, San Francisco's Mayor and Department of Health Director have publicly stated their commitment to maintaining San Francisco's health care program under the Ordinance, which they say is vitally needed to fill "major holes" in the new federal program.[4] The Mayor's rationale for maintaining the Ordinance applies with equal force to every state and major city in the country. The government offers no reason to believe that other cities or states will not want to establish their own fill-the-holes programs.

At a broader level, it is important to keep in mind that the Ninth Circuit's rationale is not limited to health care programs. It can be applied with equal force to other welfare benefit programs, even to

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[4] *See* Heather Knight, *Healthy San Francisco Expected To Continue*, S.F. Chron., Mar. 23, 2010, *available at* http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2010/03/23/MN4V1CJO00.DTL ("[O]n Monday, Mayor Gavin Newsome and Public Health Chief Mitch Katz said they are dedicated to ensuring the viability of Healthy San Francisco because major holes in the national plan, if signed into law, will leave out thousands of local residents."); Victoria Colliver, *National Plan Wouldn't Mean End of Healthy S.F.*, S.F. Chron., Nov. 23, 2009, *available at* http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2009/11/23/MNC31ALDNM.DTL (noting similar point being made by San Francisco Department of Public Health Director).

pension programs. It is difficult to overstate the importance of the issue.

Second, the Solicitor General argues that the PPACA *might* bear on whether the Ordinance is preempted, so therefore the Court should decline to hear the case now. SG's Brief at 15. But the PPACA itself does not preempt state and local "play or pay" laws, nor does it exempt them from ERISA's preemption regime. Petitioner's Supp. Brief at 2-7. It is silent.

The government's argument, nonetheless, invites readers in opaque language to assume that state or local employer mandates like San Francisco's *may* qualify for official sanction under the PPACA's provisions establishing "insurance exchanges" and, if so, *may* be saved from ERISA preemption. But the government never quite explains how this is possible, and a review of the statutory text shows that it plainly is not.

The PPACA sections cited by the government require the states or, upon their failure to act, the federal government to establish insurance exchanges through which individuals and small businesses can purchase health insurance that meets minimum specified coverage standards. *See* PPACA §§ 1311(b), 1321(c); *see also* Brian Kopp et al., "New Federal Health Care Reform Legislation – Its Impact on Employers and Employee Benefit Plans," 10 *Bender's Labor and Employment Law Bulletin* 197, 201 (May 2010). After 2016, states may apply for a "waiver" of

certain statutory requirements "with respect to health insurance coverage." PPACA § 1332(a)(1).[5]

Contrary to the government's speculation, nothing in the PPACA's waiver provision so much as hints that a state or local government may adopt a "play or pay" mandate as part an alternative program that can be removed from ERISA's preemptive reach through a waiver. A waiver can only be granted if the Secretary of the Health and Human Services makes certain determinations that meet statutory criteria, none of which contemplate the existence of a state or local "play or pay" program. To ensure that the government ***cannot*** grant the very waiver the SG's brief suggests might be available, the statute affirmatively provides: "The Secretary may not waive under this section any Federal law or requirement that is not within the authority of the Secretary." PPACA § 1332(c).

This last point is worth considering further, because it completely refutes the government's argument that 29 U.S.C. section 1144(d)—which provides that nothing in ERISA's general preemption rule in section 1144(a) shall be construed to "impair" any other federal law—might be implicated by a PPACA

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[5] The applicable statutory requirements are those: (i) relating to the "qualified health plans" and "essential health benefits" that must be available for purchase through the state insurance exchanges, PPACA §§ 1301 to 1304; 1401(a) (adding new 26 U.S.C. § 36B), 1402; (ii) governing the establishment and maintenance of the insurance exchanges themselves, *id.* §§ 1311 to 1313; and (iii) contained in the employer and individual mandates that the PPACA adds to the Internal Revenue Code, *id.* §§ 1501(b) (adding new 26 U.S.C. § 5000A); 1513 (adding new 26 U.S.C. § 4980H). *See* PPACA § 1332(a)(2).

waiver. PPACA section 1332(c) expressly precludes that possibility. There is no credible basis for claiming that the San Francisco Ordinance and similar employer mandates might be shielded from ERISA preemption under these or any other provisions of the PPACA.

The government additionally argues that San Francisco's Ordinance *may* be preempted by the PPACA because it is a local law that might not be captured by the PPACA's savings clause, which merely references "state" laws, not local laws. *See* PPACA § 1321(d).[6] But under this Court's existing cases, it appears that the reference to "state" laws includes local laws, in the absence of a clear expression of congressional intent to the contrary. *See Wisconsin Public Intervenor v. Mortier*, 501 U.S. 597, 607 (1991) (holding that federal statute expressly allowing "State" regulation but remaining silent on local laws does not contemplate preemption of local laws); *City of Columbus v. Ours Garage & Wrecker Service, Inc.*, 536 U.S. 424 (2002) (following *Mortier* even when the statutory scheme uses the phrase "a State or political subdivision of a State" in one section and the lone term "State" in another). Even if the Ordinance is not saved by section 1321(d), the fact that it is separately preempted by the PPACA is not a reason for the Court to avoid resolving the conflict in the circuits over the straightforward and important question of whether ERISA trumps "play or pay" laws such as the Ordinance.

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[6] Section 1321(d) is discussed at greater length in Petitioner's Supplemental Brief, and provides: "Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title."

III. CONTRARY TO ITS CURRENT POSITION, THE DEPARTMENT OF LABOR PREVIOUSLY HAD NO DIFFICULTY SEEING THE PANEL'S INCORRECT APPLICATION OF THIS COURT'S ERISA PREEMPTION CASES OR THE CONFLICT WITH *FIELDER*.

In this Court, the government devotes more than four pages to arguing that the panel's decision does not "directly" conflict with either this Court's ERISA decisions or the Fourth Circuit's decision in *Fielder*, which the government now says is merely in "tension" with the panel's decision. SG Brief at 17-21. But the government's argument is completely undermined by the far more persuasive case to the contrary that the government made in the Ninth Circuit.

There, the Department of Labor made two simple and devastating points. First, the Department explained, under this Court's ERISA preemption cases, "29 U.S.C. § 1144(a) is 'intended to ensure that plans *and plan sponsors* would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives *among states* or between states and the Federal Government . . . [and to prevent] the *potential for conflict* in substantive law.'" DOL Rehearing Brief at 14 (emphasis, ellipses and brackets supplied by Labor Department) (quoting *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656 (1995) and citing *Egelhoff v. Egelhoff*, 532 U.S. 141, 151 (2001)). The Ninth Circuit, the Department explained, failed to consider the potential for conflict with "play or pay" laws that other jurisdictions have enacted or considered, and instead imposed an impermissible

burden on plan sponsors and administrators to monitor, coordinate and comply with differing obligations. *Id.* at 15.

Second, the Department quoted from *Fielder* at length to demonstrate that the Fourth Circuit's decision was not based solely on its conclusion that the only way to comply with the Maryland law was to adopt or amend an ERISA plan. As the Department's brief cogently explained:

> The court reasoned that because 'the vast majority of any employer's health care spending occurs through ERISA plans . . . the primary subjects of the [law] are ERISA plans, and any attempt to comply with the [law] would have direct effects on the employer's ERISA plans.' *Id.* The court further reasoned that 'a proliferation of similar laws in other jurisdictions would force [employers] to monitor these varying laws and manipulate [their] healthcare spending to comply with them, and that such efforts would deny covered employers a uniform nationwide administration of their healthcare plans.' *Id.* at 197.

DOL Rehearing Brief at 17 (brackets and ellipses supplied by Labor Department). The Department then explained that the Ninth Circuit's decision was in conflict with *Fielder* because it "failed to address the Fourth Circuit's conclusion that even if an employer has meaningful ways to comply with a healthcare spending requirement without affecting ERISA plans, the law is still preempted because of its interference with the employer's ability to administer a uniform nationwide healthcare plan." *Id.* Earlier this term, this Court made very similar "uniformity" points in articulating ERISA's "guiding principles." *Conkright v. Frommert*, 130 S. Ct. 1640, 1648-51

(2010); *see* Petitioner's Supplemental Brief at 7-9 (discussing *Conkright*).

Nothing the government says in its brief now even comes close to detracting from the compelling points it previously advanced in the Ninth Circuit. Moreover, the Solicitor General's argument here that "the Fourth Circuit's view that the Maryland law would disrupt uniformity of plan administration also reflected in part that court's conclusion that the state-payment option was not a realistic alternative for Wal-Mart" is completely refuted by the government's brief in the court below. *Compare* SG Brief at 19 *with* DOL Rehearing Brief at 17.

IV. THE GOVERNMENT'S FOCUS ON A REGULATION THAT THE LABOR DEPARTMENT NEVER PROMULGATED IS WHOLLY MISPLACED.

The government notes that the Labor Department considered, but decided not to promulgate after the PPACA's passage, a regulation "'clarifying the circumstances under which health care arrangements established or maintained by state or local governments for the benefit of non-governmental employees do not constitute an employee welfare benefit plan' covered by ERISA." SG Brief at 12. Had it done so, the government argues, the regulation would have been entitled to *Chevron* deference. *Id.* at 12-13. From this the government asks the Court to draw two inferences: that the contemplated regulation "*could* have altered the preemption analysis in this case" and that the government's decision not to proceed supports its contention that the PPACA re

duces the importance of the question presented in this case. Neither inference is warranted.

First, whether the contemplated regulation "could" have altered the preemption analysis is irrelevant, as the Department never adopted it. In the absence of a genuine legislative regulation that satisfies each *Chevron* element, the government's flip-flop on the issues, occurring within the same case no less, precludes it from receiving any deference whatsoever. *See Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 212-13 (1988) (holding that government's flip-flop in case where agency litigating position is "wholly unsupported by regulations, rulings, or administrative practice" not entitled to deference). Moreover, it is hard to imagine a regulation of the sort mentioned by the government that properly could circumscribe ERISA's preemptive scope under 29 U.S.C. section 1144(a).

Second, the government neglects to mention that its published notice of intended rulemaking provoked strong criticism from the ERISA and business communities.[7] It is at least as inferable that the proposed regulation was dropped in response to the criticism as it was due to a belief that the importance of ERISA's preemption of "play or pay" laws was reduced by the PPACA's passage.

V. CONCLUSION.

The government's argument that the PPACA reduces the need for granting the Petition holds no

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[7] A letter protesting the proposed regulation from the American Benefits Council and 12 other organizations representing plan sponsors, for example, can be found at http://americanbenefitscouncil.org/documents/erisa_omb-letter032910.pdf.

water. Its other arguments fare even worse, toppling mostly from the pull of the government's earlier opposing positions on the same points. Telling in the government's brief is what it does not say – it does not argue that the Ordinance survives ERISA preemption. This is a remarkable concession by the government given the weakness of the arguments it does make. The question presented in this case and the conflict in the circuits remains urgently in need of resolution. The new position taken by the government, if anything, increases the necessity for this Court to clarify the scope of ERISA preemption, especially in the context of a state or local government imposing new employer mandates, the scope of which can be determined only by reference to ERISA covered employee benefit plans.

Respectfully submitted,

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REPLY BRIEF

(10)

No. 08-1515

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IN THE

Supreme Court of the United States

GOLDEN GATE RESTAURANT ASSOCIATION,
Petitioner,

v.

CITY AND COUNTY OF SAN FRANCISCO,
Respondent,

SAN FRANCISCO CENTRAL LABOR COUNCIL, *et al.*,
Intervenors / Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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On Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

REPLY BRIEF FOR PETITIONER

INTRODUCTION

As the Petition demonstrates, the Ninth Circuit's decision, unless reversed, will undermine ERISA's central purpose of having federal law, not state or local law, regulate the design, funding and administration of employee benefit plans. The decision will effectively nullify Congress's goal of fostering the growth and development of a purely voluntary system of cost-effective plans with nationally-uniform benefits, benefit levels and administrative practices governed by a single body of federal law.

In the sharpest of conflicts with ERISA, the "pay-or-play" and "fair-share" laws require the "'tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction,'" *see, e.g., Egelhoff v. Egelhoff*, 532 U.S. 141, 151 (2001), while upending ERISA's purpose of "minimiz[ing] the need for interstate employers to administer their plans differently in each State." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 105 (1983).

ERISA's preemptive scope ensures that plan sponsors may enjoy economies of scale in setting up and administering a nationally-uniform system of employee benefit plans. Nationally-uniform plans may provide better benefits and higher payment levels than smaller, localized plans set up and administered on a person-by-person or location-by-location basis. If state or local laws shatter these economies of scale, the additional high costs of healthcare and administration services ultimately will fall on the workers' shoulders in the form of less benefits, *see, e.g., Egelhoff*, 532 U.S. at 149-150, lower wages, or fewer jobs, all contrary to ERISA's goals.

Respondent's opposition ignores these overarching ERISA considerations in favor of a parochial "San Francisco first" approach. In so doing, Respondent attempts to raise emotional appeals and distracting non-issues, while steadfastly denying the dramatic conflict between the Fourth and Ninth Circuits. Respondent also tries, unsuccessfully, to defend the Ninth Circuit's decision which, through incorrect readings of the statute and case law, subverts rather than upholds this Court's carefully-crafted ERISA preemption standards and the important ERISA goals they protect.

Properly viewed, Respondent's arguments spotlight the compelling reasons this Court should grant, not deny, the Petition.

I. THIS CASE PRESENTS A QUESTION THAT IS BOTH RECURRING AND OF EXCEPTIONAL NATIONAL SIGNIFICANCE

Respondent argues that Petitioner greatly exaggerates the impact of the Ninth Circuit's decision. (Brief in Opposition ("Opposition"), 31-35). Respondent misses the mark.

Larger forces are at play than just San Francisco's Health Care Security Ordinance. There is a clear conflict between the Fourth and Ninth Circuits on whether ERISA preempts "pay-or-play" or "fair-share" laws, and employers as well as states, cities and counties need to know what they can and cannot do. Under currently harsh economic conditions, more and more jurisdictions will likely experiment with healthcare reform models and employer mandates similar to San Francisco's local clinic-based program until there is definitive Supreme Court guidance.

Eight of the Ninth Circuit Judges dissenting from the denial of *en banc* rehearing recognized this crucial point. Concluding that "this case concerns an issue of exceptional national importance," they observed that the "panel decision creates a 'road map for state and local governments' seeking to regulate employee health plans despite ERISA's preemptive scope." (App. at 58a, 49a (citation omitted)). Similarly, the Secretary of Labor accurately stated in her *amicus* brief supporting rehearing: "this case raises a recurring issue of exceptional importance concerning the extent to which ERISA permits recent attempts by state or local governments to require employers

to pay for or provide medical benefits for their employees" (*id.* at 72a).

Two preeminent ERISA scholars have singled out the Fourth and Ninth Circuit decisions as worthy of close study and contrast. Edward A. Zelinsky, "Employer Mandates and ERISA Preemption: A Critique of *Golden Gate Restaurant Association v. San Francisco*," Cardozo Legal Studies Working Paper No. 246, 31 (2008), *available at* http://ssrn.com/abstract=1299128 ("Zelinsky Working Paper 246") ("At some point, it will be necessary for the Supreme Court to resolve the conflict represented by *Fielder* and *Golden Gate II*"); John H. Langbein, *et. al*, *Pension & Employee Benefit Law* (4th ed. 2006) (2009 Supplement, containing both the *Fielder* and *Golden Gate II* texts, the only opinions reprinted other than Supreme Court opinions). *See also* Joshua Waldbeser, Case Note: *"Golden Gate Restaurant Association v. . . . San Francisco*: Setting the Stage for Supreme Court Review of the Most Important Preemption Matter in the History of ERISA," 41 J. Marshall L. Rev. 995 (2008).

As of 2006, "pay-or-play" laws and "fair-share" laws had been proposed or were under consideration by at least 30 states as well as local jurisdictions across the country.[1] Seven "pay-or play" or "fair-share" laws have already been enacted (Hawaii; San Francisco; Massachusetts; Vermont; Maryland (struck down); Suffolk County (struck down); New York City (not enforced due to concerns over ERISA preemption).[2] In view of the sharply conflicting decisions from the

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[1] Julia Contreras and Orly Lobel, "Wal-Martization and the Fair Share Health Care Acts," 19 St. Thomas L. Rev. 105, 136 (2006).

[2] *Id.*; Petition at 6.

Fourth and Ninth Circuits, many proposals are on "hold."

All eyes are now on this Petition for Writ of Certiorari to see whether this Court will intervene. If not, it is reasonable to expect a far more rapid growth in "pay-or-play" and "fair-share" laws from coast-to-coast.

II. THIS IS AN APPROPRIATE CASE FOR SUPREME COURT REVIEW

Because of the emotional tone in Respondent's Brief in Opposition, a few words of background are necessary to clear the air about the appropriateness of this case for Supreme Court review.

Notwithstanding Respondent's quibbles (Opposition, 35-37), this case contains a detailed and fully-developed record sufficient for this Court to decide the question presented. The District Court ruled on the Ordinance in an exhaustive manner (App. at 83a-103a), as did the Ninth Circuit, twice (App. at 1a-40a, 41a-61a).

Respondent states that there has been a "health care crisis" in San Francisco; the Ordinance has caused the "number of uninsured" to decline by tens of thousands; and reversal of the Ninth Circuit's decision will have a devastating impact because the employer-contribution mandate is an "interlocking component[]" with the "public" program. (Opposition, 1, 37). These assertions are overstated, unsupported and, above all, irrelevant to the Petition.

Respondent concedes that prior to the Ordinance, roughly 90% of medium and large businesses in San Francisco provided employee health insurance. (Opposition, 3). This suggests that the real problem

has not been a healthcare crisis at the employer level. Rather, it suggests that the difficulty is San Francisco wants to provide more generous healthcare benefits to all of its residents than its tax base will sustain.

The Health Access Plan ("HAP") established by the Ordinance is not insurance. Nor is it portable. The HAP consists of local clinics for city residents. The "Healthy San Francisco" website summarizes its limitations correctly:

> Healthy San Francisco is not insurance. . . . The program does not include vision or dental care. If you receive medical care outside of San Francisco for any reason, Healthy San Francisco will not pay for it.[3]

Respondent's claim that San Francisco's public health program will be devastated if the Ninth Circuit's decision is reversed is not true. The City's published statistics show that the overwhelming majority of HAP funding comes not from employer contributions, but from local taxes, grants and other San Francisco revenues.[4] Moreover, employer contributions to HAP equal less than four-tenths of one percent of the City's annual budget.[5] "Healthy San Francisco" is not at risk.

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[3] www.healthysanfrancsisco.org, last visited on Aug. 25, 2009.

[4] *See* July 2009 Status Report on the Implementation of the San Francisco Health Care Security Ordinance; at 13, 16 ($113.2 million funding; with $22.643 million from employers), *available at* www.healthysanfrancisco.org/about-us.Reports.aspx.

[5] Mayor's Proposed City Budget 2009-2010, 21 ($6.6 billion budget), www5.2/gov.org/.../2009/...mayor-newsom-releases-2009.

Respondent also attempts, unsuccessfully, to argue that the ERISA preemption issue will become moot if national healthcare reform legislation is enacted. (Opposition, 39). None of the federal proposals deals with preemption of state and local employer mandates either through an amendment to ERISA or otherwise.[6] The Fourth Circuit and Ninth Circuit decisions will remain in sharp conflict.

Further, if there is a legislative stalemate, the ERISA preemption issue will become even more acute because additional state and local governments may feel compelled to enact "pay-or-play" or "fair-share" laws based on a "tested" model such as San Francisco's Ordinance. Respondent never explains how the nation's employee benefit plan system and the employer community will survive if 50 states and over 38,000 counties, cities and towns experiment with various types of "pay-or-play" or "fair-share" laws.

If, as San Francisco urges,[7] states, cities and counties follow its model of local clinics with employer mandates, the results will also be draconian. First, there will be an enormous disruption of a nationally-uniform and cost-effective system of employee benefit plans that is ERISA's paradigm. Second, when a person with protection similar to the HAP travels to another city, county or state, the clinic's protection is left behind. Each local jurisdiction will be providing only basic clinic care for its own residents. All of this

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[6] A proposed amendment to H.R. 3200 provides an ERISA preemption waiver for certain state single-payer systems.

[7] Jason Dearen, "Federal Court Upholds San Francisco Healthcare Program," *Los Angeles Times*, Sept. 30, 2008 (quoting City Attorney Dennis Herrera).

will lead to a balkanization and shrinkage of employee healthcare, the opposite of ERISA's goal.

San Francisco's conundrum illustrates that healthcare reform is a national problem—one perhaps best resolved by affordable health insurance coupled with tax-incentives and subsidies—that requires national healthcare and health insurance reforms, all in harmony with ERISA's goal of allowing cost-effective, nationally-uniform employee benefit plans.

III. THIS COURT SHOULD PROMPTLY RESOLVE THE CONFLICT BETWEEN THE FOURTH AND NINTH CIRCUIT DECISIONS

Respondent denies any conflict between the Ninth Circuit's decision and *Retail Indus. Leaders Assoc. v. Fielder*, 473 F.3d 180 (4th Cir. 2007). Respondent overlooks most of the *Fielder* court's analysis and ignores the many similarities between the laws considered in each case.

The Fourth Circuit explained that under the Maryland statute, "the only rational choice employers have . . . is to structure their ERISA healthcare plans so as to meet the minimum spending threshold." *Fielder*, 473 F.3d at 196. San Francisco employers spending less than the mandated amounts on an existing plan will feel compelled to raise their expenditures, just as in *Fielder*. Those paying nothing will also feel compelled to establish a healthcare plan matching the Ordinance's rate, just as in *Fielder*. In both cases, a rational employer is likely to conclude that because the local-government program produces either no benefit for employees (Maryland), or a local-clinic benefit that is not insurance and not portable (San Francisco), the appropriate response is to raise the

existing contribution level, or establish a new plan, to square with the law. Each rational employer, whether in Maryland or San Francisco, must design or abandon plans using the local law as the yardstick. Although there is a difference between the laws, it is only a difference in degree.

While the Fourth Circuit concluded the Maryland Act offered no reasonable alternative for employers to comply without altering an ERISA plan, it pointedly rejected the one-dimensional litmus test adopted by the Ninth Circuit. As explained by Respondent, the Ninth Circuit held that a local jurisdiction may impose any restriction or obligation on a plan sponsor as long as the law contains a "reasonable" alternative to compliance that does not require the sponsor to create or alter an existing ERISA plan. (Opposition, 8, 11, 14).

ERISA preemption does not turn on alternatives to compliance. Citing *Egelhoff*, 532 U.S. at 151, the Fourth Circuit correctly held that a "state law that directly regulates the structuring or administration of an ERISA plan is not saved by inclusion of a means of opting out of its requirements. *Fielder*, 473 F.3d at 192. Although Respondent now contends that this issue was "not presented to, or considered by, the Ninth Circuit" (Opposition, 16), eight dissenting Judges from the denial of rehearing *en banc* properly criticized the panel decision for attempting to ignore this portion of *Fielder*'s holding, a portion that demonstrates the very conflict the panel tried to deny. (App. at 54a-55a).

IV. THIS COURT SHOULD PROMPTLY REAFFIRM THAT ERISA PREEMPTS LAWS MANDATING EMPLOYER CONTRIBUTIONS FOR EMPLOYEE BENEFITS

Respondent also contends that the San Francisco Ordinance escapes preemption because, in its view, ERISA preempts only laws relating to employee benefits, but not laws mandating employer contributions (or "expenditures" as Respondent prefers to say) necessary to fund the benefits. (Opposition, 24-31). The Ninth Circuit's distinction between "benefits" and "contributions" is sophistry. Professor Zelinsky carefully explains that this distinction "does not withstand analysis":

> There is no support in the statute or in the Supreme Court's case law for this benefits/ contributions distinction . . . .[8]
>
> The San Francisco ordinance does not merely "relate to" ERISA plans. The ordinance intrudes deeply and comprehensively into such plans, even more deeply and comprehensively than did the Maryland Wal-Mart law.[9]

This Court should promptly intervene in order to reaffirm and apply the proper ERISA preemption standard it has carefully-framed over the past 25 years. In protecting ERISA's goal of cost-efficient, uniform nationwide plans, this Court has held that ERISA preempts *all* state and local laws, such as the Ordinance, that "prohibit" what is "permitted" by federal law, *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658

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[8] Zelinsky Working Paper 246, 20.

[9] *Id.* at 29.

(1995), "mandate[] employee benefit structures", *id.*, require a sponsor to create, alter or amend an ERISA plan, *Egelhoff*, 532 U.S. at 145-146, or impose "different regulations on plans and plan sponsors from jurisdiction to jurisdiction," regardless of the existence of an "opt out" provision, *id.* at 145-146.

Similarly, ERISA preempts all state and local laws—similar to the Ordinance—mandating employer contributions for group health-insurance, with a non-compliance penalty, *e.g.*, *Standard Oil Co of Calif. v. Agsalud*, 633 F.2d 760 (9th Cir. 1980), *summarily aff'd*, 454 U.S. 801 (1981), requiring plans to provide specific types of benefits, *Shaw*, *supra*, or requiring employers to provide benefits equal to a specific standard, *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125, 129-130 (1992).

Further, Respondent argues that the Ordinance escapes ERISA preemption because it operates only indirectly on employers and employee benefit plans, similar to the New York fee-surcharge statute in *Travelers, supra*. (Opposition, 12). Professor Zelinsky pinpointed this error with accuracy:

> San Francisco's employer mandate is explicitly and narrowly targeted only at employers and their health care plans, whether these plans self-insure, purchase coverage from insurers or other providers, make ongoing payments to the City, or do some combination of these.
>
> . . .
>
> This employer mandate is no less direct and targeted because it decrees the contributions which

employers' plans must receive rather than the benefits such plans must pay.[10]

The Ordinance also violates the "connection with" and "reference to" prongs of ERISA's preemption standard because the City-payment-option itself requires the creation of an ERISA plan. The employer's ongoing-contributions to HAP and compliance with a maze of recordkeeping and reporting and disclosure rules establish an ERISA health "plan, fund, or program" for its employees financed "through the purchase of insurance or otherwise." 29 U.S.C. § 1002(1). For ERISA's purposes, an employer's HAP-contributions are indistinguishable from premium payments to an insurance company or a PPO for health-coverage that result in an ERISA plan.[11]

In arguing the City-payment-option does not involve an ERISA plan, Respondent simply repeats a fundamental error by the Ninth Circuit. (Opposition, 20-21).[12] For an ERISA plan to exist, there is no requirement that the employer hold trust fund assets

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[10] Zelinsky Working Paper 246, 27.

[11] *Id.* at 8.

[12] Respondent also asserts that the Ordinance escapes preemption because it "is utterly indifferent to whether an employer has an ERISA plan." (Opposition, 15). The ERISA preemption standard is not "indifference" but this Court's fine-tuned standard, described above. Further, a primary purpose of the Ordinance's contribution-mandate is to encourage employers to retain existing ERISA plans, thus avoiding a flight to less expensive public options ("crowding out") (*see Amicus* Briefs of Zazie and Medjool Restaurants for Respondent, 26). Petitioner presented unrebutted evidence to the District Court showing that Respondent's Board of Supervisors believed and intended that the Ordinance would help to avoid this effect. (Declaration of Patrick Sutton, Document 57, filed 8/3/07).

for ERISA to protect from mismanagement. The Ninth Circuit seized on ERISA's general prohibitions against employer mismanagement of plan assets to read into ERISA's broad definition of "employee welfare benefit plan" a limitation that Congress itself chose not to insert. Most ERISA-covered employee welfare benefit plans, including insured and PPO-modeled healthcare plans, do not involve the handling of plan assets.[13] The Ninth Circuit's theory is a "classic legal argument which proves too much" since very few, if any, insured health-plans, third-party administered plans, or HMO-plans would be ERISA-covered under this restrictive standard."[14]

Lastly, Respondent protests that Petitioner's City-payment-option argument lacks authority. (Opposition, 19-23). The Secretary of Labor's *amicus* brief,[15] however, and Paul J. Ondrasik, *et al.*, "ERISA Preemption and State Health Care Reform," Infrastructure, Vol. 47, No. 4, 4 (2008) American Bar Association, concluded that an employer's use of the City-payment-option creates an ERISA plan within the statutory definition, thus triggering preemption. After a detailed analysis, Professor Zelinsky concluded that a Supreme Court holding that ERISA preempts the Ordinance, based on an application of the statutory definition to the City-payment-option, is "the most compelling of the possible dispositions."[16]

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[13] *See, e.g., Qualls v. Blue Cross of California*, 22 F.3d 839 (9th Cir. 1994); *Brundage-Peterson v. Compcare Health Services Ins. Co.*, 877 F.2d 509, 511 (7th Cir. 1989).

[14] Zelinsky Working Paper 246, 13, 16, 19.

[15] App. at 85-86a.

[16] "*Golden Gate III*, ERISA Preemption, and the San Francisco Health Care Security Ordinance," Cardozo Working Paper No. 261 (Apr. 2009), 16, *available at* http://ssrn.com/abstract=1396356.

CONCLUSION

For the foregoing reasons, as well as on the grounds advanced in the Petition and by the *amici curiae*, a Writ of Certiorari should issue to review the opinion of the Ninth Circuit in this case.

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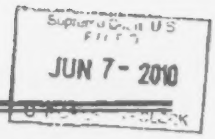

IN THE

Supreme Court of the United States

GOLDEN GATE RESTAURANT ASSOCIATION,
Petitioner,

v.

CITY AND COUNTY OF SAN FRANCISCO,
Respondent,

SAN FRANCISCO CENTRAL LABOR COUNCIL, *et al.*,
Intervenors/Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

PETITIONER'S REPLY TO SOLICITOR GENERAL'S BRIEF

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QUESTION PRESENTED

Whether ERISA section 514(a), 29 U.S.C. § 1144(a), preempts local laws mandating ongoing employer contributions for employee health benefits, or alternative payments to a local government, and extensive recordkeeping and reporting and disclosure requirements, a question on which the courts of appeals are in conflict.

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On Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

PETITIONER'S REPLY TO SOLICITOR GENERAL'S BRIEF

In accordance with Supreme Court Rule 15.8, Petitioner respectfully submits this Reply to the Solicitor General's Brief.

I. INTRODUCTION.

In the Ninth Circuit, the Department of Labor filed an amicus brief arguing, correctly, that this case raises "an important question" and that the employer mandate in San Francisco's Ordinance is completely preempted by ERISA because it requires employee

benefit structures or their administration and it interferes with uniform plan administration. Labor Secretary's Amicus Brief at 1, 8-9. After the panel upheld the Ordinance, the Department of Labor took a full month to consider the court's opinion, then filed a second amicus brief supporting Petitioner's request for a rehearing en banc and arguing, once again correctly, that this case raises "a recurring issue of exceptional importance," that the Ordinance is clearly preempted because it mandates employee benefit structures or their administration and interferes with uniform plan administration, and that the panel's decision conflicts with *Retail Industry Leaders Association v. Fielder*, 475 F.3d 180 (4th Cir. 2007), and with this Court's ERISA preemption cases. Labor Secretary's Brief in Support of Rehearing ("DOL Rehearing Brief") at 7, 14-17.

In the 19 months that have since passed, the government has had a change in administration and a change of heart, at least in part. In this Court, the Solicitor General and the Department of Labor now argue that the ERISA preemption question in this case is not very important and that the Circuit conflict may merely reflect "tension" between the Fourth and Ninth Circuits. Significantly, however, they do not reverse themselves on the underlying legal merits – they do not claim that the San Francisco Ordinance actually survives ERISA preemption.

They seek to justify their partial reversal by asserting that passage of the Patient Protection and Affordable Care Act,[1] as amended[2] (the "PPACA"),[3]

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[1] Pub. L. No. 111-148, 124 Stat. 119.

[2] Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

reduces the likelihood that state and local governments will adopt new employer spending requirements. But the only affirmative evidence bearing on this theory tends to refute it. San Francisco's Mayor and Department of Public Health Director have recently vowed to keep the City's health care program under the Ordinance intact because they say it is needed to fill "holes" in PPACA's coverage.

By reversing itself in part to now advocate that the Ninth Circuit's departure from ERISA preemption law be allowed to stand, the government unintentionally amplifies the need for clarification by this Court that ERISA preempts state and local mandates—regardless of whether the mandates are for benefits or contributions—and that local jurisdictions may not pass laws that balkanize the regulation of employee benefit plans. The Court therefore should grant the petition and decide the important question presented by this case.

II. THE PPACA DOES NOT COUNSEL AGAINST GRANTING THE PETITION.

The Solicitor General invokes Congress's recent passage of the PPACA to make a two-fold argument against granting the Petition.

First, the SG argues that because the PPACA "will almost certainly significantly increase health care coverage" in the United States, the new law "make[s] it much less likely that States and localities will

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[3] The House Office of the Legislative Counsel has created a consolidated document that integrates the original and amending provisions of Public Law Nos. 111-148 and 111-152 into a single text. *See* http://www.neal.org/documents/health/ppaca-consolidated.pdf.

choose to adopt their own health care programs." SG's Brief at 15. This according to the SG "reduces substantially the ongoing importance of the question whether ERISA preempts state and local health care programs like the [Ordinance]." *Id.* We respectfully disagree with the government on at least two levels.

At the most basic level, the government's position is undermined by the very party the government seeks to support. Twice since Respondent filed its opposition brief, San Francisco's Mayor and Department of Health Director have publicly stated their commitment to maintaining San Francisco's health care program under the Ordinance, which they say is vitally needed to fill "major holes" in the new federal program.[4] The Mayor's rationale for maintaining the Ordinance applies with equal force to every state and major city in the country. The government offers no reason to believe that other cities or states will not want to establish their own fill-the-holes programs.

At a broader level, it is important to keep in mind that the Ninth Circuit's rationale is not limited to health care programs. It can be applied with equal force to other welfare benefit programs, even to

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[4] *See* Heather Knight, *Healthy San Francisco Expected To Continue*, S.F. Chron., Mar. 23, 2010, *available at* http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2010/03/23/MN4V1CJO00.DTL ("[O]n Monday, Mayor Gavin Newsome and Public Health Chief Mitch Katz said they are dedicated to ensuring the viability of Healthy San Francisco because major holes in the national plan, if signed into law, will leave out thousands of local residents."); Victoria Colliver, *National Plan Wouldn't Mean End of Healthy S.F.*, S.F. Chron., Nov. 23, 2009, *available at* http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2009/11/23/MNC31ALDNM.DTL (noting similar point being made by San Francisco Department of Public Health Director).

pension programs. It is difficult to overstate the importance of the issue.

Second, the Solicitor General argues that the PPACA *might* bear on whether the Ordinance is preempted, so therefore the Court should decline to hear the case now. SG's Brief at 15. But the PPACA itself does not preempt state and local "play or pay" laws, nor does it exempt them from ERISA's preemption regime. Petitioner's Supp. Brief at 2-7. It is silent.

The government's argument, nonetheless, invites readers in opaque language to assume that state or local employer mandates like San Francisco's *may* qualify for official sanction under the PPACA's provisions establishing "insurance exchanges" and, if so, *may* be saved from ERISA preemption. But the government never quite explains how this is possible, and a review of the statutory text shows that it plainly is not.

The PPACA sections cited by the government require the states or, upon their failure to act, the federal government to establish insurance exchanges through which individuals and small businesses can purchase health insurance that meets minimum specified coverage standards. *See* PPACA §§ 1311(b), 1321(c); *see also* Brian Kopp et al., "New Federal Health Care Reform Legislation – Its Impact on Employers and Employee Benefit Plans," 10 *Bender's Labor and Employment Law Bulletin* 197, 201 (May 2010). After 2016, states may apply for a "waiver" of

certain statutory requirements "with respect to health insurance coverage." PPACA § 1332(a)(1).[5]

Contrary to the government's speculation, nothing in the PPACA's waiver provision so much as hints that a state or local government may adopt a "play or pay" mandate as part an alternative program that can be removed from ERISA's preemptive reach through a waiver. A waiver can only be granted if the Secretary of the Health and Human Services makes certain determinations that meet statutory criteria, none of which contemplate the existence of a state or local "play or pay" program. To ensure that the government ***cannot*** grant the very waiver the SG's brief suggests might be available, the statute affirmatively provides: "The Secretary may not waive under this section any Federal law or requirement that is not within the authority of the Secretary." PPACA § 1332(c).

This last point is worth considering further, because it completely refutes the government's argument that 29 U.S.C. section 1144(d)—which provides that nothing in ERISA's general preemption rule in section 1144(a) shall be construed to "impair" any other federal law—might be implicated by a PPACA

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[5] The applicable statutory requirements are those: (i) relating to the "qualified health plans" and "essential health benefits" that must be available for purchase through the state insurance exchanges, PPACA §§ 1301 to 1304; 1401(a) (adding new 26 U.S.C. § 36B), 1402, (ii) governing the establishment and maintenance of the insurance exchanges themselves, *id* §§ 1311 to 1313; and (iii) contained in the employer and individual mandates that the PPACA adds to the Internal Revenue Code, *id.* §§ 1501(b) (adding new 26 U.S.C. § 5000A); 1513 (adding new 26 U.S.C. § 4980H). *See* PPACA § 1332(a)(2).

waiver. PPACA section 1332(c) expressly precludes that possibility. There is no credible basis for claiming that the San Francisco Ordinance and similar employer mandates might be shielded from ERISA preemption under these or any other provisions of the PPACA.

The government additionally argues that San Francisco's Ordinance *may* be preempted by the PPACA because it is a local law that might not be captured by the PPACA's savings clause, which merely references "state" laws, not local laws. *See* PPACA § 1321(d).[6] But under this Court's existing cases, it appears that the reference to "state" laws includes local laws, in the absence of a clear expression of congressional intent to the contrary. *See Wisconsin Public Intervenor v. Mortier*, 501 U.S. 597, 607 (1991) (holding that federal statute expressly allowing "State" regulation but remaining silent on local laws does not contemplate preemption of local laws); *City of Columbus v. Ours Garage & Wrecker Service, Inc.*, 536 U.S. 424 (2002) (following *Mortier* even when the statutory scheme uses the phrase "a State or political subdivision of a State" in one section and the lone term "State" in another). Even if the Ordinance is not saved by section 1321(d), the fact that it is separately preempted by the PPACA is not a reason for the Court to avoid resolving the conflict in the circuits over the straightforward and important question of whether ERISA trumps "play or pay" laws such as the Ordinance.

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[6] Section 1321(d) is discussed at greater length in Petitioner's Supplemental Brief, and provides: "Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title."

III. CONTRARY TO ITS CURRENT POSITION, THE DEPARTMENT OF LABOR PREVIOUSLY HAD NO DIFFICULTY SEEING THE PANEL'S INCORRECT APPLICATION OF THIS COURT'S ERISA PREEMPTION CASES OR THE CONFLICT WITH *FIELDER*.

In this Court, the government devotes more than four pages to arguing that the panel's decision does not "directly" conflict with either this Court's ERISA decisions or the Fourth Circuit's decision in *Fielder*, which the government now says is merely in "tension" with the panel's decision. SG Brief at 17-21. But the government's argument is completely undermined by the far more persuasive case to the contrary that the government made in the Ninth Circuit.

There, the Department of Labor made two simple and devastating points. First, the Department explained, under this Court's ERISA preemption cases, "29 U.S.C. § 1144(a) is 'intended to ensure that plans *and plan sponsors* would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives *among states* or between states and the Federal Government . . . [and to prevent] the *potential for conflict* in substantive law.'" DOL Rehearing Brief at 14 (emphasis, ellipses and brackets supplied by Labor Department) (quoting *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins Co.*, 514 U.S. 645, 656 (1995) and citing *Egelhoff v. Egelhoff*, 532 U.S. 141, 151 (2001)). The Ninth Circuit, the Department explained, failed to consider the potential for conflict with "play or pay" laws that other jurisdictions have enacted or considered, and instead imposed an impermissible

burden on plan sponsors and administrators to monitor, coordinate and comply with differing obligations. *Id.* at 15.

Second, the Department quoted from *Fielder* at length to demonstrate that the Fourth Circuit's decision was not based solely on its conclusion that the only way to comply with the Maryland law was to adopt or amend an ERISA plan. As the Department's brief cogently explained:

> The court reasoned that because 'the vast majority of any employer's health care spending occurs through ERISA plans . . . the primary subjects of the [law] are ERISA plans, and any attempt to comply with the [law] would have direct effects on the employer's ERISA plans.' *Id.* The court further reasoned that 'a proliferation of similar laws in other jurisdictions would force [employers] to monitor these varying laws and manipulate [their] healthcare spending to comply with them, and that such efforts would deny covered employers a uniform nationwide administration of their healthcare plans.' *Id.* at 197.

DOL Rehearing Brief at 17 (brackets and ellipses supplied by Labor Department). The Department then explained that the Ninth Circuit's decision was in conflict with *Fielder* because it "failed to address the Fourth Circuit's conclusion that even if an employer has meaningful ways to comply with a healthcare spending requirement without affecting ERISA plans, the law is still preempted because of its interference with the employer's ability to administer a uniform nationwide healthcare plan." *Id.* Earlier this term, this Court made very similar "uniformity" points in articulating ERISA's "guiding principles." *Conkright v. Frommert*, 130 S. Ct. 1640, 1648-51

(2010); *see* Petitioner's Supplemental Brief at 7-9 (discussing *Conkright*).

Nothing the government says in its brief now even comes close to detracting from the compelling points it previously advanced in the Ninth Circuit. Moreover, the Solicitor General's argument here that "the Fourth Circuit's view that the Maryland law would disrupt uniformity of plan administration also reflected in part that court's conclusion that the state-payment option was not a realistic alternative for Wal-Mart" is completely refuted by the government's brief in the court below. *Compare* SG Brief at 19 *with* DOL Rehearing Brief at 17.

IV. THE GOVERNMENT'S FOCUS ON A REGULATION THAT THE LABOR DEPARTMENT NEVER PROMULGATED IS WHOLLY MISPLACED.

The government notes that the Labor Department considered, but decided not to promulgate after the PPACA's passage, a regulation "'clarifying the circumstances under which health care arrangements established or maintained by state or local governments for the benefit of non-governmental employees do not constitute an employee welfare benefit plan' covered by ERISA." SG Brief at 12. Had it done so, the government argues, the regulation would have been entitled to *Chevron* deference. *Id.* at 12-13. From this the government asks the Court to draw two inferences: that the contemplated regulation "*could* have altered the preemption analysis in this case" and that the government's decision not to proceed supports its contention that the PPACA re

duces the importance of the question presented in this case. Neither inference is warranted.

First, whether the contemplated regulation "could" have altered the preemption analysis is irrelevant, as the Department never adopted it. In the absence of a genuine legislative regulation that satisfies each *Chevron* element, the government's flip-flop on the issues, occurring within the same case no less, precludes it from receiving any deference whatsoever. *See Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 212-13 (1988) (holding that government's flip-flop in case where agency litigating position is "wholly unsupported by regulations, rulings, or administrative practice" not entitled to deference). Moreover, it is hard to imagine a regulation of the sort mentioned by the government that properly could circumscribe ERISA's preemptive scope under 29 U.S.C. section 1144(a).

Second, the government neglects to mention that its published notice of intended rulemaking provoked strong criticism from the ERISA and business communities.[7] It is at least as inferable that the proposed regulation was dropped in response to the criticism as it was due to a belief that the importance of ERISA's preemption of "play or pay" laws was reduced by the PPACA's passage.

V. CONCLUSION.

The government's argument that the PPACA reduces the need for granting the Petition holds no

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[7] A letter protesting the proposed regulation from the American Benefits Council and 12 other organizations representing plan sponsors, for example, can be found at http://americanbenefitscouncil.org/documents/erisa_omb-letter032910.pdf.

water. Its other arguments fare even worse, toppling mostly from the pull of the government's earlier opposing positions on the same points. Telling in the government's brief is what it does not say – it does not argue that the Ordinance survives ERISA preemption. This is a remarkable concession by the government given the weakness of the arguments it does make. The question presented in this case and the conflict in the circuits remains urgently in need of resolution. The new position taken by the government, if anything, increases the necessity for this Court to clarify the scope of ERISA preemption, especially in the context of a state or local government imposing new employer mandates, the scope of which can be determined only by reference to ERISA covered employee benefit plans.

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CITY AND COUNTY OF SAN FRANCISCO, CALIFORNIA,
ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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QUESTION PRESENTED

Whether the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1144(a), preempts the provisions of San Francisco's Health Care Security Ordinance, S.F. Cal. Admin. Code §§ 14.1-14.8 (2007), mandating that covered employers in San Francisco spend a specified amount for health care benefits for their covered employees.

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BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

INTEREST OF THE UNITED STATES

This brief is submitted in response to the order of this Court inviting the Solicitor General to express the views of the United States. In the view of the United States, the petition for a writ of certiorari should be denied.

STATEMENT

1. In 2006, respondent City and County of San Francisco (City) enacted the Health Care Security Ordinance (HCSO), S.F. Cal. Admin. Code. §§ 14.1-14.8, to provide health care for its uninsured residents. The HCSO has two primary components: the Health Access Plan (HAP) and employer spending requirements. Pet. App. 3a.

The HAP is a public health care program, operated by the City, which provides health care through a network of public and private providers. The HAP is primarily funded by city taxes but also receives part of its funding from employer payments under the HCSO and from payments by participating individuals. All San Francisco residents who lack health insurance and meet age and income requirements are eligible to participate in the HAP whether or not they are employed. Participants in the HAP pay income-based fees, and employees who are covered by the employer spending provisions of the HCSO may enroll at a significantly reduced rate. Pet. App. 3a, 8a, 113a-115a.

The employer spending requirements mandate that covered employers make minimum "health care expenditures" to or on behalf of covered employees each calendar quarter. "Covered employers" are for-profit employers engaged in business within the City that have an average of at least 20 paid employees during the quarter and non-profit employers that have an average of at least 50 paid employees. "Covered employees" are individuals who work within the City for a certain minimum number of hours each week, have worked for the employer for at least 90 days, and are not otherwise excluded from coverage. Pet. App. 5a-6a, 107a-109a, 127a-128a, 130a-135a.

The required expenditures are determined by multiplying the total number of hours worked by each covered employee during the quarter by the applicable "health care expenditure rate." The current rate is either $1.23 or $1.85 per hour, depending on the type and size of the employer, but the rate may increase in future years based on projections from an annual ten-county

survey of health care spending. Pet. App. 6a, 111a, 139a-140a.

The HCSO defines "health care expenditures" as "any amount paid by a covered employer to its covered employees or to a third party on behalf of its covered employees for the purpose of providing health care services for covered employees or reimbursing the cost of such services for its covered employees." Pet. App. 110a. Eligible "health care expenditures" include but are not limited to (1) contributions on behalf of covered employees to federal health savings accounts or other accounts having substantially the same purpose or effect; (2) reimbursement of expenditures by covered employees for health care services; (3) payments to third parties for the provision of health care services to covered employees; (4) costs incurred in providing direct delivery of health care services to covered employees; and (5) payments to the City to be used on behalf of covered employees (the city-payment option). The City uses funds received under the city-payment option either to fund membership of covered employees in the HAP (if the employees are eligible to participate) or to fund medical reimbursement accounts for the covered employees (if the employees are not eligible). *Id.* at 7a-8a, 110a-111a, 135a-137a.

The HCSO includes a number of recordkeeping requirements to ensure compliance with the health care spending obligations. Employers must keep records of health care expenditures and proof that the required expenditures are made each quarter; they must provide the City with the information necessary to determine employees' eligibility to participate in the HAP or to establish medical reimbursement accounts; and they must notify employees if they are making payments to the

City to satisfy the health care spending requirements. Employers who fail to comply with the spending or recordkeeping requirements may be subject to administrative action, including monetary penalties. Pet. App. 9a, 116a-119a, 142-144a, 149a-154a.

2. a. After the HCSO was enacted, petitioner, a trade association for the City's restaurant industry, filed suit in the United States District Court for the Northern District of California, contending that the HCSO's spending requirements are preempted by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1144(a). Subject to certain exceptions not implicated here, ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." *Ibid.* Under ERISA, employee benefit plans include "welfare plan[s]," which in turn include "any plan, fund, or program * * * established or maintained by an employer * * * for the purpose of providing for its participants or their beneficiaries" medical care or benefits. 29 U.S.C. 1002(1).

b. The district court granted summary judgment in favor of petitioner. Pet. App. 83a-103a. The court concluded that the HCSO's spending requirements "relate to" ERISA-covered employee benefit plans within the meaning of Section 1144(a). *Id.* at 93a. The court explained that state or local laws "relate to" ERISA plans under that provision if they are "connected with" or "make reference to" ERISA plans. *Id.* at 89a (citing *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983)). The court concluded that the HCSO's spending requirements are connected with ERISA plans because they interfere with nationally uniform administration of plans, affect the structure and administration of plans, and mandate the provision of benefits covered by plans.

Id. at 93a-98a. The court also found that the HCSO's spending requirements make unlawful reference to ERISA plans because the vast majority of employers conduct their health care spending through ERISA plans and, in order to enforce the spending requirements, the City will have to ascertain whether and how much employers are paying for health care coverage under their existing ERISA plans. *Id.* at 98a-102a.

3. a. The City, along with several unions that had intervened in the lawsuit, sought a stay of the district court's judgment pending appeal. The district court denied their request, but the court of appeals granted a stay. Pet. App. 3a-4a. In granting the stay, the court of appeals concluded that the City had a strong likelihood of success on the merits of the preemption issue. *Golden Gate Rest. Ass'n* v. *City & County of S.F.*, 512 F.3d 1112, 1114 (9th Cir. 2008).

b. After briefing and argument on the merits, including by the Department of Labor, which argued that ERISA preempts the HCSO's spending requirements, the court of appeals reversed the district court's judgment. Pet. App. 1a-40a. The court first concluded that employers can comply with the spending requirements without creating or changing ERISA plans because they can utilize the city-payment option. *Id.* at 15a-26a. The court rejected the position that the record-keeping, reporting, and payment obligations employers assume when they choose the city-payment option in themselves constitute the creation of an ERISA plan. *Id.* at 16a-23a. The court reasoned that, under the city-payment option, an employer has no responsibility other than to calculate and make the required payments to the City for covered employees and to retain records to show that it has done so. *Id.* at 18a. The court observed that

those administrative obligations are similar to obligations imposed on employers under many federal, state, and local tax laws. *Id.* at 19a. The court similarly concluded that the employers' responsibilities under the city-payment option do not involve sufficient discretion to constitute an "ongoing administrative scheme," which is necessary to qualify as an ERISA plan. *Id.* at 20a (citation omitted).

The court then rejected the proposition that the City's HAP itself is an ERISA plan. Pet. App. 23a-26a.[1] The court observed that the HAP is a government entitlement program, administered by the City and available to City residents regardless of their employment status. *Id.* at 24a. In addition, the court noted, the City, rather than any employer, controls eligibility and coverage decisions and determines the kind and level of benefits. *Id.* at 25a-26a.

The court of appeals also rejected the contention that the HCSO has an impermissible connection with ERISA plans because it interferes with uniform administration of ERISA plans. Pet. App. 26a-32a. The court reasoned that the HCSO does not require any employer to adopt an ERISA plan, to provide specific benefits, or to follow particular rules in administering any ERISA plan that the employer may provide. *Id.* at 29a-31a. The court acknowledged that the HCSO imposes administrative burdens on covered employers, but concluded that those burdens do not impermissibly interfere with plan administration because they exist whether or not an employer has an ERISA plan. *Id.* at 32a.

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[1] Contrary to the court's statement (see Pet. App. 23a-24a), the Department of Labor did not argue that the HAP is itself an ERISA plan. See *id.* at 68a, 77a.

The court of appeals further concluded that the HCSO's spending requirements do not make a forbidden "reference" to ERISA plans because the requirements "can have [their] full force and effect even if no employer in the City has an ERISA plan." Pet. App. 33a. The court noted that an employer's obligations under the HCSO are not measured by the level of benefits provided by an ERISA plan but by the payments that the employer provides either to a plan or to another entity, such as the City. *Id.* at 35a.

Finally, the court of appeals rejected petitioner's contention that the HCSO would be preempted under the analysis adopted by the Fourth Circuit in *Retail Industry Leaders Ass'n* v. *Fielder*, 475 F.3d 180 (2007), which held that a Maryland law mandating a specified level of health care expenditures was preempted. Pet. App. 36a-40a. The court reasoned that, unlike the Maryland law, which gave employers no realistic method of compliance that did not involve an ERISA plan, the HCSO gives employers the city-payment option, which in the court's view does not entail creation of an ERISA plan. The court explained that the city-payment option is a realistic alternative for employers because, unlike the state-payment option under the Maryland law in *Fielder*, the city-payment option gives employers something in return for their payments—health care benefits for their employees. *Id.* at 38a-40a.

c. Petitioner sought rehearing en banc, which the Department of Labor supported in a second amicus brief. See Pet. App. 82a. The court of appeals denied the petition for rehearing, with eight judges dissenting from the denial and one judge concurring and writing to respond to the dissent. *Id.* at 41a-61a.

DISCUSSION

In the court of appeals, the Department of Labor took the position that ERISA preempts the employer health care spending requirements of San Francisco's HCSO because an employer can comply with those requirements only by creating or altering an ERISA plan. After the court of appeals rejected that position, the Department of Labor began to reexamine its views and was considering the promulgation of a regulation clarifying when state and local health care programs result in the creation of ERISA plans. Because that regulation would have been entitled to deference under *Chevron U.S.A. Inc.* v. *NRDC*, 467 U.S. 837 (1984), it could have affected the preemption analysis in this case. Since then, however, Congress has enacted comprehensive national health care legislation. Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, 124 Stat. 119; Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152, 124 Stat. 1029. Although the federal legislation accommodates state authority over regulation of health insurance, it significantly reduces the potential that state or local governments will choose to enact health care programs like the HCSO and may also affect the question whether such programs are preempted by federal law. For these reasons, the Department of Labor has decided that regulatory action would be premature at this time. For the same reasons that the Department has decided that regulatory action affecting the ERISA preemption issue would be premature, this Court's review of the issue is not warranted at this time. Accordingly, the petition for a writ of certiorari should be denied.

1. Subject to exceptions not applicable here, ERISA preempts "any and all State laws insofar as they may

now or hereafter relate to any employee benefit plan." 29 U.S.C. 1144(a). ERISA defines the term "State" to include subdivisions and agencies of a State, such as the City and County of San Francisco, and defines "State law" to include "rules, regulations, or other State action having the effect of law," 29 U.S.C. 1144(c)(1) and (2), which include ordinances such as the HCSO.

This Court has explained that a law "relate[s] to any employee benefit plan," 29 U.S.C. 1144(a), "in the normal sense of the phrase, if it has a connection with or reference to such a plan." *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645, 656 (1995) (*Travelers*) (citation omitted). But the Court has cautioned against conducting that analysis with an "uncritical literalism," and has stressed that whether a law has a prohibited connection with ERISA plans turns on whether the law interferes with ERISA's core objectives. *Ibid.*

One core objective of ERISA is "to protect * * * the interests of participants * * * and their beneficiaries" in those plans. 29 U.S.C. 1001(b); see 29 U.S.C. 1001(a), 1001a(c), 1001b(c). Another core objective of ERISA, and its preemption provision in particular, "is to provide a uniform regulatory regime over employee benefit plans," *Aetna Health Inc.* v. *Davila*, 542 U.S. 200, 208 (2004), by "establish[ing] the regulation of * * * benefit plans as exclusively a federal concern," *Travelers*, 514 U.S. at 656 (citation and internal quotation marks omitted).

In light of these purposes, this Court has held that a state law has a prohibited connection with ERISA plans if it "mandate[s] employee benefit structures or their administration." *Travelers*, 514 U.S. at 658. See, *e.g.*, *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983)

(finding state law related to ERISA plans because it mandated provision of specific benefits). State laws are also preempted if they "interfere[] with nationally uniform plan administration." *Egelhoff* v. *Egelhoff*, 532 U.S. 141, 148 (2001). Accordingly, ERISA preempts not only state laws that mandate the provision of benefits or require plans to calculate benefit levels differently in different locations, see *Travelers*, 514 U.S. at 657-658, but also state laws that mandate the creation of ERISA plans, see *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 16-17 (1987).

In the court of appeals, the Department of Labor took the position that ERISA preempts the HCSO's employer spending requirements because those requirements both mandate employee benefit structures and interfere with the uniformity of plan administration. See C.A. Br. for the Sec'y of Labor as Amicus Curiae Supporting Appellee and Requesting Affirmance 11-28 (Labor Department Br.); Pet. App. 73a-79a. Central to that position was the Department's conclusion that "all of the options for compliance" with the HCSO "require an employer to create or alter an ERISA plan." Labor Department Br. 11.

The court of appeals did not dispute that, in the case of employers that do not already make health care expenditures at the level mandated by the HCSO's spending requirements, many of the options that the HCSO provides for compliance will involve employers' altering existing ERISA plans or establishing new ones. But the court concluded that "the City-payment option allows employers to make payments directly to the City, if they so choose, without requiring them to establish, or to alter existing, ERISA plans." Pet. App. 12a. The Department of Labor disagreed with that conclusion, instead

taking the view that when an employer complies with the HCSO's spending requirements by utilizing the city-payment option, the administrative undertakings that the employer must assume constitute the creation of an ERISA-covered plan. *Id.* at 73a-75a; see Labor Department Br. 12-19.

The Department of Labor reasoned that ERISA defines an "employee welfare benefit plan" to include "any plan, fund, or program * * * established or maintained by an employer * * * for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, * * * medical, surgical, or hospital care or benefits." 29 U.S.C. 1002(1). Accordingly, an employer creates a plan whenever it establishes "an ongoing administrative scheme" for the provision of medical or other covered benefits. *Fort Halifax Packing Co.*, 482 U.S. at 18.

The Department of Labor explained that use of the city-payment option requires an employer to establish an ongoing administrative scheme because, each calendar quarter, the employer must determine which employees are covered by the HCSO's spending requirements and how much is due for those covered employees. In the Department's view, those calculations sometimes require employers to make discretionary decisions, without clear guidance from the HCSO, about who is covered and to what extent. Labor Department Br. 14-15. For that reason, the Department concluded that an employer utilizing the city-payment option "establishes an ERISA-covered plan for its employees, just as an employer establishes an ERISA-covered plan when it provides health benefits for its employees through the purchase of insurance." Pet. App. 74a-75a (citing *Qualls* v. *Blue Cross of Cal., Inc.*, 22 F.3d 839, 843 (9th Cir.

1994) (holding that an employer's purchase of insurance for its employees creates an ERISA-covered plan)). The Department perceived "no relevant difference" between the two scenarios, noting that, "in both cases, the employees receive their benefits from a third party and the program is substantially administered by a third party." *Id.* at 75a.

After the court of appeals' extensive analysis of the HCSO and the court's rejection of the Department of Labor's position, the Department began to reexamine its view. The court of appeals had emphasized the limited amount of discretion exercised by employers under the city-payment option and the fact that the City, rather than the employer, determines the terms, structure, and administration of the program. Pet. App. 20a, 25a-26a. In light of those facts, a difficult question arises about whether an employer's role under the city-payment option more closely resembles the collection and payment of a payroll tax to support a government health program (which does not involve the creation of an ERISA plan) than it does the purchase of health insurance from a private company (which does involve the creation of an ERISA plan). As part of the reconsideration process, the Department stated that it planned to issue a proposed regulation "clarify[ing] the circumstances under which health care arrangements established or maintained by state or local governments for the benefit of non-governmental employees do not constitute an employee welfare benefit plan" covered by ERISA. 74 Fed. Reg. 64,276 (2009).

The Secretary of Labor has broad authority to prescribe such regulations as she finds "necessary or appropriate" to carry out the provisions of Title I of ERISA. 29 U.S.C. 1135. The Secretary's authority includes the

power to promulgate regulations defining what constitutes a "plan" within the meaning of Title I. See *Massachusetts* v. *Morash*, 490 U.S. 107, 116-117 (1989). The Secretary's reasonable interpretation of what constitutes an ERISA-covered "plan" is entitled to *Chevron* deference. See *id.* at 116. Therefore, had the Secretary promulgated a regulation clarifying whether and when employers' coverage under local programs like the HCSO does or does not entail creation of ERISA plans, that regulation would have been entitled to *Chevron* deference and could have altered the preemption analysis in this case.

The Department of Labor has, however, decided not to proceed with a proposed regulation at this time because of the recent passage of comprehensive federal health care legislation. See PPACA, Pub. L. No. 111-148, 124 Stat. 119; HCERA, Pub. L. No. 111-152, 124 Stat. 1029. As discussed in more detail below (see pp. 14-17, *infra*), the federal legislation has significantly changed the legal landscape governing health care spending requirements. In particular, the legislation includes provisions designed to encourage the provision and availability of health insurance that reduce substantially the likelihood that state and local governments will choose to enact new employer spending requirements like those contained in San Francisco's HCSO. The federal legislation therefore significantly reduces the importance of the question whether and when such requirements are preempted by ERISA. See pp. 14-15, *infra*. In addition, it is unclear whether the new federal requirements may have independent preemption consequences for local legislation or may affect the preemption analysis under ERISA. See pp. 15-17, *infra*.

For these reasons, in light of the new federal legislation, the Department of Labor has concluded that, at present, it would be premature to proceed with regulatory action. In the unlikely event that additional state or local governments choose to enact health care spending requirements like the HCSO, the Department might reconsider whether the preemption issue has sufficient ongoing significance to warrant administrative action to address it.

2. The preemption issue does not warrant this Court's review at this time for the same reasons that the Department of Labor has determined not to take regulatory action on the issue at this time.

First, the new federal health care legislation contains numerous provisions designed to promote broader access to health care coverage. Those provisions include an employer shared responsibility provision that imposes assessments on employers with 50 or more full-time equivalent employees that do not provide health insurance to their employees if any full-time employee receives a premium tax credit in new health insurance exchanges. See PPACA § 1513, as amended by HCERA § 1003. The legislation also includes a requirement that non-exempted individuals maintain a minimum level of health insurance or pay a penalty. See PPACA § 1501, as amended by HCERA § 1002. And the legislation provides for automatic enrollment of employees in group health plans offered by large employers, PPACA § 1511, and contains several other provisions designed to make health care coverage more affordable and available, *e.g.*, *id.* § 1401, as amended by HCERA § 1001 (premium assistance tax credits); PPACA § 1402, as amended by HCERA § 1001 (reduced cost-sharing); PPACA § 1421

(small business tax credits); and *id.* § 1311 (state-based insurance exchanges).

Many of the new provisions will be phased in over several years, and three different federal agencies—the Department of Health and Human Services, the Department of the Treasury, and the Department of Labor—will be promulgating regulations implementing the provisions. The full contours and effects of many aspects of the new federal framework therefore remain to be fleshed out. Nonetheless, although the new provisions accommodate state authority over regulation of health insurance, they will almost certainly significantly increase health care coverage. They therefore make it much less likely that States and localities will choose to adopt their own health care programs. Accordingly, the federal health care legislation reduces substantially the ongoing importance of the question whether ERISA preempts state and local health care programs like the HCSO.

In addition, unresolved issues about the preemptive force of the new federal legislation may affect the question whether local health care programs like the HCSO are preempted by federal law. The new legislation contemplates a significant role for the States in promoting the availability of health care coverage. For example, the States are authorized to create and administer exchanges for the purchase of health insurance by individuals and employers. The States have substantial flexibility in the operation of those exchanges and the enforcement of related requirements, including the ability to obtain waivers that authorize the establishment of alternative programs. See PPACA §§ 1311-1333. In light of the significant role anticipated for the States, the legislation includes a provision saving certain state

laws from preemption by the newly enacted federal provisions. See *id.* § 1321(d) ("Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title."). At present, however, the savings provision has not been interpreted by any Department or court. For example, the responsible federal Departments and the courts have not addressed whether the PPACA's savings provision applies to laws enacted by state subdivisions, such as the HCSO, or only to laws enacted by the States themselves. Compare *id.* § 1034(d) (defining "State," for purposes of the federal health care legislation, to mean "each of the 50 States and the District of Columbia") with 29 U.S.C. 1144(e)(2) (defining "State," for purposes of ERISA, to include "any political subdivisions thereof, or any agency or instrumentality of either"); but see *Wisconsin Pub. Intervenor* v. *Mortier*, 501 U.S. 597, 606-608 (1991) (interpreting the term "State" in the Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA), 7 U.S.C. 136 *et seq.*, to include local governments, even though FIFRA's definition does not expressly include political subdivisions).

If local health care programs like the HCSO were somehow independently preempted by the new health care legislation, that would further reduce the importance of the question whether such laws would otherwise be preempted by ERISA. If, on the other hand, local health care programs were saved from preemption under the new health care legislation, that consequence could, in turn, alter the analysis of whether those programs would be preempted by ERISA, perhaps depending on the relationship between the local programs and the implementation of the new legislation. As a general matter, a savings provision, such as Section 1321(d) of

the PPACA, that shields state (or local) laws from preemption by only one federal statute has no effect on preemption by other federal statutes. But, unlike most other federal statutes, ERISA expressly provides that it shall not "be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States." 29 U.S.C. 1144(d). When state or local laws are integral to the operation of a federal law other than ERISA, Section 1144(d)'s prohibition on "impair[ing]" other federal laws may shield those state or local laws from ERISA preemption. See *Shaw*, 463 U.S. at 100-102.

At this early stage, the responsible federal Departments and the courts have not addressed the possible relationship between state or local laws like the HCSO and the new federal legislation—*e.g.*, whether such laws might form the basis for waivers under Section 1332 of the PPACA of provisions concerning the creation of insurance exchanges. There accordingly is not yet a foundation for assessing whether or how ERISA Section 1144(d) could be implicated by the implementation of the new health care legislation. These considerations provide still further reasons why this Court's review of the ERISA preemption issue is not warranted at this time.

3. a. Petitioner contends (Pet. 15-34) that the Court should grant review because the decision below purportedly conflicts with the Fourth Circuit' s decision in *Retail Industry Leaders Ass'n* v. *Fielder*, 475 F.3d 180 (2007). Although some of the reasoning contained in *Fielder* is in tension with reasoning in the decision below, the two cases do not present a direct conflict that warrants this Court's review.

Fielder involved a Maryland law requiring employers with 10,000 or more Maryland employees to spend at least eight percent of their total payrolls on health in-

surance costs for their employees or to pay the amount that their spending falls short to the State. The law was nominally of general application, but it covered only Wal-Mart Stores, Inc., and it was designed to force Wal-Mart to increase the health insurance benefits that it provided under an ERISA plan. *Fielder*, 475 F.3d at 183. The Fourth Circuit held that the Maryland law was preempted by ERISA because "the only rational choice employers" had to comply with the law was "to structure their ERISA healthcare benefit plans so as to meet the minimum spending threshold." *Id.* at 193. Although employers theoretically had the alternative of paying money to the State, the court concluded that no rational employer would select that option because the employer and its employees would receive nothing in return. *Ibid.*

As the court below explained, unlike the state-payment option under the Maryland law, the HCSO's city-payment option is a realistic alternative for employers because it offers them something in return for their payments—health care benefits for their employees. Pet. App. 38a-40a. Indeed, almost 900 employers had selected the city-payment option at the time of the district court's summary judgment ruling. See Br. in Opp. App. 33. The court below did not dispute that, if the city-payment option itself effectively required creation of ERISA plans by participating employers, the HCSO, like the Maryland law, would be preempted. See Pet. App. 15a. But the court concluded that the city-payment option does not entail creation of an ERISA plan. *Id.* at 15a-26a. That assessment of the operation of the HCSO does not itself give rise to any conflict with the Fourth Circuit's decision in *Fielder*, which did not suggest that an employer's election of the state-payment option under the Maryland statute would entail creation of an

ERISA plan. And, because that assessment of the HCSO was the underlying premise of the court of appeals' ultimate decision in this case, its preemption ruling does not conflict with *Fielder*.

The Fourth Circuit also stated in *Fielder* that, even assuming that an employer could comply with the Maryland law without creating an ERISA plan (such as by providing on-site medical clinics or health savings accounts), the law would still have an impermissible "connection with" ERISA plans because it would interfere with "uniform nationwide" plan administration by requiring employers "to keep an eye on conflicting state and local minimum spending requirements and adjust [their] healthcare spending accordingly." 475 F.3d at 196-197. That reasoning could also be applied to the HCSO, and it is therefore in tension with the decision below, as the Department of Labor pointed out in its brief supporting rehearing en banc in the court of appeals. Pet. App. 80a-81a. But the Fourth Circuit's view that the Maryland law would disrupt uniformity of plan administration also reflected in part that court's conclusion that the state-payment option was not a realistic alternative for Wal-Mart, the one covered employer. That conclusion does not apply to the HCSO, which the court below also concluded does not impose burdens significantly different from those necessary to comply with tax laws of various state and local jurisdictions. *Id.* at 19a. It is therefore not clear that the Fourth Circuit would find that a law such as the HCSO poses the same threat to uniformity of plan administration as the Maryland law and further find such a law preempted on that ground alone.

In any event, this Court "reviews judgments, not statements in opinions," *Black* v. *Cutter Labs.*, 351 U.S.

292, 297 (1956), and the judgment in *Fielder* does not conflict with the judgment below because, as interpreted, the laws at issue in the two cases have fundamental differences. As understood by the Fourth Circuit, the Maryland law in *Fielder* effectively forced the single affected employer to alter its ERISA plan; but, as understood by the court below, the HCSO does not require employers to alter or create any ERISA plans.

b. Contrary to petitioner's contention, the decision below does not directly conflict with this Court's ERISA decisions. Unlike the law that the Court held preempted in *Shaw*, the HCSO does not require employers to provide specific benefits. Compare *Shaw*, 463 U.S. at 97 (holding New York law preempted because it "require[d] employers to pay employees specific benefits"), with Pet. App. 29a (noting that, unlike the law in *Shaw*, the HCSO does not "require any employer to provide specific benefits through an existing ERISA plan or other health plan"). Similarly, this Court concluded that the law in *Egelhoff* was preempted because it offered no method of compliance that did not require a change in the way an ERISA plan was operated or written. 532 U.S. at 151. In this case, in contrast, the court of appeals concluded that employers can comply with the HCSO without creating or amending an ERISA plan. See Pet. App. 29a-30a.

Finally, the decision below does not directly conflict with either *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133 (1990), or *District of Columbia* v. *Greater Washington Board of Trade*, 506 U.S. 125 (1992). The law that this Court held preempted in *Ingersoll-Rand Co.* was "premised on[] the existence of [an ERISA] plan" because, in order to prevail on a claim under the law, the plaintiff had to establish "that an ERISA plan exist-

[ed]." 498 U.S. at 140. Here, in contrast, under the view of the court of appeals that the city-payment option does not require employers to create ERISA plans, an employer can comply with the HCSO even if it has no ERISA plans. Pet. App. 33a. The HCSO also differs from the local ordinance that this Court held preempted in *Greater Washington Board of Trade* because, under that ordinance, employers were required to provide workers' compensation benefits at the same level provided by their existing ERISA plans. See 506 U.S. at 130. Under the HCSO, an employer's payment obligation is based on the hours worked by covered employees. Although an employer may receive a credit against its obligation for other health-related expenditures, including those made under an ERISA plan, an employer may also receive credit for payments made to the City (which, under the court of appeals' view, do not involve an ERISA plan). Pet. App. 34a-35a.

c. In any event, even had a square conflict materialized in the courts of appeals, review by this Court would not be warranted. As discussed above, the intervening enactment of comprehensive federal health care legislation has dramatically changed the landscape governing payment for health care, substantially reducing the importance of the question whether ERISA preempts state or local requirements and also giving rise to additional legal issues that have not been addressed by the federal Departments responsible for implementing the new legislation or by the courts. Accordingly, this Court's review of the ERISA preemption issue is not warranted at this time.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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In The Supreme Court of the United States

GOLDEN GATE RESTAURANT ASSOCIATION,
Petitioner,

v.

CITY AND COUNTY OF SAN FRANCISCO,
Respondent,

SAN FRANCISCO CENTRAL LABOR COUNCIL, ET AL.,
Intervenors/Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF OF THE AMERICAN BENEFITS COUNCIL AND HR POLICY ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

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BRIEF OF THE AMERICAN BENEFITS COUNCIL AND THE HR POLICY ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF THE PETITION FOR A WRIT OF CERTIORARI

The American Benefits Council (the "Council") and the HR Policy Association (the "Association") (together, "*amici*") submit this amicus brief urging this Court to review the Ninth Circuit's decision in *Golden Gate Restaurant Association v. City and County of San Francisco, et al.*, 546 F.3d 639 (9th Cir. 2008) (hereinafter "Decision" or "*GGRA*"). The Decision held that the San Francisco Health Care Security Ordinance ("Ordinance") is not preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"). The Decision disregards Supreme Court precedent and conflicts with the United States Court of Appeals for the Fourth Circuit's decision on an issue of national importance.

INTEREST OF *AMICI*

The Council is a broad-based, nonprofit trade association founded in 1967 to protect and foster the growth of the Nation's privately sponsored employee benefit plans.[1] The Council's members are primarily

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[1] No counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amici curiae*, its members, or its counsel made a monetary contribution to its preparation or submission. Counsel of record for all parties received notice at least 10 days prior to the due date of the *amici curiae*'s intention to file this brief.

large employer-sponsors of employee benefit plans, including many Fortune 500 companies. Its members also include employee benefit plan support organizations, such as actuarial and consulting firms, insurers, banks, investment firms, and other professional benefit organizations. Collectively, the Council's more than 250 members sponsor and administer plans covering more than 100 million plan participants and beneficiaries.

HR Policy Association brings together the chief human resources officers of more than 270 of the largest corporations in the United States. Representing every major industrial sector, the Association's member companies employ more than 18 million employees. All of HR Policy's member companies operate employee welfare benefit plans. In addition, many of the companies also provide similar health benefits to retired employees and dependents.

This case is of significant national importance to employer-sponsors of health benefits plans and their employees. Members of the Council and the Association offer some of the Nation's most generous and well-managed health benefit plans which cover employees that reside in many states, counties, and cities. If the Ordinance and other similar "pay-or-play" laws are allowed, it will create a "regulatory balkanization" that would strike at the heart of the purpose of ERISA preemption, which is to encourage employers to establish comprehensive health plans

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The parties' letters consenting to the filing of this brief have been filed with the Clerk's office.

for their employees without regard to the particular state or locality in which they live. This decision creates a roadmap for thousands of jurisdictions to enact similar laws, each with individual requirements necessitating the allocation of significant resources to ensure compliance. The result will be to increase employer costs for providing health and welfare benefits—costs which are inevitably shared with employees through increased premiums, deductibles or other out-of-pocket expenses.

SUMMARY OF ARGUMENT

Congress is in the midst of enacting comprehensive legislation for the national health care problem. The legislation will be implemented through a variety of measures that will inevitably conflict with the scheme adopted by the City. This fact alone counsels this court to accept this case to minimize such future conflicts. Moreover, even if Congress fails to adopt comprehensive federal health care legislation, left uncorrected, the Decision fundamentally undermines ERISA preemption for all employee benefit plans, not just health plans. *Golden Gate Restaurant Association v. City and County of San Francisco, et al.*, 558 F.3d 1000, 1007, 1008 (9th Cir. 2008) (hereinafter "*GGRA II*") (*en banc* dissent from rehearing concluding that the Decision "strike[s] at the heart of ERISA" and "greatly revises ERISA preemption case law.") Following the reasoning of the Ninth Circuit's decision, there is nothing to prevent states or localities from establishing similar "pay or play" schemes for any type of employee benefit—including pension plans, disability plans, life insurance plans—whenever state or local officials determine. Simply put, as a result of this Decision, the field that was

once entirely occupied by the federal government—pension and welfare plan benefits—will be divvied up between a myriad of federal, state and local governmental interests.

The dissent to *en banc* rehearing recognized as much, noting that the Decision "allows San Francisco to create an ordinance that effectively requires 'ERISA administrators to master the relevant laws of 50 States'—which in turn 'undermine[s] the congressional goal of 'minimiz[ing] the administrative and financial burden[s]' on plan administrators—burdens ultimately born by the beneficiaries.'" *Id.* (quoting *Egelhoff v. Egelhoff,* 532 U.S. 141 (2001)). Such a result contravenes Supreme Court precedent and creates a split of authority with the Fourth Circuit. Further, following this Decision, "similar laws will become commonplace, and the congressional goal of national uniformity in the area of employer-provided healthcare will be thoroughly undermined, with significant adverse consequences to employers and employees alike." *Id.* at 1004.

ARGUMENT

I. RESOLVING THIS CASE WILL FOSTER CONGRESSIONAL EFFORTS TO ADOPT COMPREHENSIVE HEALTH CARE REFORM.

It might be argued that pending federal health care legislation weighs in favor of this Court declining certiorari in this case. But failing to take this case at this time would undermine federal efforts and will be disastrous for employers that provide health benefits. It is essential that this Court grant the Petition to address this nationally significant

question and to reaffirm the long-standing interpretation of ERISA's preemption provisions.

Congress is poised to enact comprehensive legislation to address the national health care problem. Such legislation would be implemented through a variety of measures that will inevitably conflict with the scheme adopted by the City. For example, the 852 page health care bill released by the House Democrats[2] would

- reform the insurance markets, requiring insurers to guarantee issue all coverage and imposing federal rating restrictions,
- establish new consumer protections relating to appeals, external review, prompt payment and remedies,
- require all Americans to purchase insurance or otherwise face federal tax penalties (the "individual mandate"),
- require all employers to provide minimum health care coverage or else otherwise pay substantial federal penalties (the "pay or play" mandate),
- establish a comprehensive new federal regulatory agency (the Health Choices Administration) that would develop

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[2] United States House of Representatives TriCommittee Health Reform Discussion Draft, June 19, 2009 version, available at http://waysandmeans.house.gov/media/pdf/111/hrdraft1xml.pdf.

sweeping new minimum benefit standards for Qualified Health Benefit Plans (which include *all* ERISA covered health plans) and administer insurance market reforms and consumer protections,

- establish a new federal Health Insurance Exchange through which employers and individuals can obtain federally regulated Qualified Health Benefit Plans,
- provide for tax credits for small employers and premium subsidies for lower income Americans, available only to employers and individuals that purchase insurance though the Health Insurance Exchange, and
- establish a new federal health care plan that competes side by side with private health insurance and is available to anyone obtaining insurance though the Health Insurance Exchange.[3]

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[3] The proposed Senate bills are similarly ambitious and similarly conflict with the Ordinance. For instance, the Committee on Health, Education, Labor, and Pensions' 615 page "Affordable Health Choices Act" would impose broad new insurance market reforms, impose an individual mandate; impose an employer "pay or play" mandate; establish state based Health Benefit Gateways (similar to the Health Insurance Exchange in the House bill); establish a public plan option; provide premium credits on a sliding scale to lower income Americans; establish minimum ("essential") benefits as determined by a Medical Advisory Council, among other initiatives. United States Senate

If the Decision stands, the approach adopted by the City will irreconcilably conflict with a new federal law in literally thousands of ways, big and small. For example, the Ordinance's spending target for employers is different than the House bill's employer spending mandate. The penalties for failing to meet the minimum employer spending level are different under each scheme. Uninsured employees in the City get coverage through the City's Health Access Program ("HAP"), but uninsured employees under the House bill would get insurance through the federal Health Insurance Exchange (including a public plan option). Employees will have access to federal premium subsidies if they are low income in the federal Health Insurance Exchange, but no such federal subsidies would be available to City residents under the City's HAP program. Small employers in San Francisco paying into the City's HAP program could not get tax credits, but such credits would be available to small employers obtaining coverage offered via the new federal Exchange. In short, the tension between the current proposals and the Ordinance is undeniable. In fact, the tension between the current federal proposals and *any* local regulation is indisputable—none of the current proposals contemplate dual federal-state regulation of em-

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Committee on Health, Education, Labor, & Pensions "Affordable Health Choices Act" draft bill, available at http://help.senate.gov/BAI09A84_xml.pdf; Amendment to "Affordable Health Choices Act" draft, available at http://dodd.senate.gov/multimedia/2009/BillText.pdf.

ployer-based health care, and none abandon or amend ERISA's preemption provision.

Clearly, if allowed to stand, the Ordinance will add a level of unwarranted confusion and complexity to the implementation of an otherwise massive federal health care reform measure, a federal-state regulatory conflict that ERISA clearly sought to limit. The Ordinance will needlessly complicate the already intricate and fiercely negotiated proposals being considered by Congress. Further, the costs, complexity and uncertainty will punish the employers that offer health benefits in San Francisco at a time when all employers are struggling to survive in the worst economic crisis since 1929. And the conflict between federal and state requirements will confound state and federal regulators alike. The San Francisco Ordinance is a well-intentioned local effort to address a vexing national problem. Although laudatory, the San Francisco effort will stand in the way of a uniform health care solution.

Even if this Court is unpersuaded that the Ordinance is preempted under ERISA, the Court should nonetheless take this case. Congress must know the legal background against which it is legislating. If San Francisco's Ordinance is not preempted under ERISA currently, as the Council and the Association believe it is, Congress must be informed of ERISA's preemptive scope and adjust its legislation accordingly. For example, as explained above, the Congressional proposals currently do not accommodate state and local regulation and in many cases, directly conflict with current local laws, including the Ordinance. Without a definitive decision from this Court regarding ERISA's preemptive scope, any

Congressional action will likely be incomplete and may require further Congressional action at the time this Court finally and inevitably resolves the preemption issue.

Importantly, this Court does not shy away from resolving deeply important national issues in the face of pending legislation. For example, while the Civil Rights Act of 1968 was pending, this Court granted certiorari and decided *Jones v. Alfred H. Mayer Co.*, 392 U.S. 409 (1968). In its decision, the Court discussed in detail how both Congressional and Court action was necessary. Congress was aware that a favorable decision by the Court might ban the particular discriminatory conduct at issue, but recognized that more comprehensive Congressional action was nonetheless needed. *Id.* at 415-16. For its part, the Court recognized that even in the face of Congressional action, the Court's decision was necessary to address the instant case and to resolve the scope of 42 U.S.C. § 1982's antidiscrimination provisions. *Id.* at 414-17 & n.21. Due to the overriding importance of this issue—and the legal uncertainty caused by the Decision below—this Court should reverse the Ninth Circuit, and reaffirm the correct ERISA preemption standards in this case, providing greater certainty to employers and employees and clarifying the law during this time of Congressional action.

II. THE DECISION ALLOWS STATE REGULATION OF ALL EMPLOYEE BENEFIT PLANS, NOT JUST HEALTH CARE PLANS.

ERISA's preemption provision represents a conscious policy choice by Congress, one that was characterized by one key sponsor as the "crowning achievement" of the ERISA legislation. 120 Cong. Rec. 29197 (1974) (Statement of Rep. Dent). The purpose of preemption is clear—to "minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government ..., [and to prevent] the potential for conflict in substantive law ... requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction." *GGRA II*, 558 F.3d at 1007 (quoting *New York State Conf. of Blue Cross and Blue Shield Plans. v. Travelers Ins. Co.*, 514 U.S. 645, 656 (1995)). In addition to being an administrative necessity, uniformity ensures that multi-state employers can offer all of their similarly situated employees the same benefits. Uniformity is a critical part of ensuring that employees understand exactly what benefits to which they are entitled and how to obtain them. *GGRA II*, 558 F.3d at 1009.

The Ninth Circuit's decision rejects any adherence to ERISA's text and this Court's precedent in favor of local and state experimentation. That policy choice was firmly and explicitly rejected by Congress when ERISA was enacted. As the legislative history of ERISA reveals, "the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus

eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans." *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 99 (1983) (quoting Senator Williams' statements in the Congressional Record).

More pernicious, however, than the immediate outcome of this Decision is that there is no limiting principle in the Decision that would prevent a state or locality from mandating that employers provide an unlimited array of benefit programs conceived of by state and local governments.

In essence, the Ninth Circuit concluded that a city, county or state could require employers to provide a certain level of benefits to their employees, or pay the locality to do so, without running afoul of ERISA. Logically then, a locality could apply this principle to require that employers must provide life insurance benefits to spouses of all employees and that such coverage must automatically be updated in the event of a divorce and remarriage. Employers that fail to comply by amending their life insurance plans would pay the local government to augment their coverage. This would be permitted under the Decision, but would clearly be at odds with this Court's decision and reasoning in *Egelhoff*. *See* 532 U.S. at 150-51 (concluding that a "statute is not any less of a regulation of the terms of ERISA plans simply because there are two ways of complying with it" and that the statute was preempted because it "'dictate[s] the choice[s] facing ERISA plans'" by leaving plan administrators only the "choice of timing *i.e.*, whether to bear the burden of compliance *ex post*, by paying benefits as the statute dictates (and in con-

travention of the plan documents), or *ex ante*, by amending the plan.").

Given the volatility of the stock market recently, a state might require every employer operating within the state to make matching contributions to all of its employees' 401(k) accounts. If the employer does not offer a 401(k) matching contribution, the state might require the employer to pay the matching amount to a state established defined contribution plan. Or a more aggressive state may decide to address the pressing problem of retirement security by giving employers precisely the same type of options offered under the current San Francisco Ordinance, but require the contributions be used to fund a defined benefit pension plan. Under such a "Pension Plan Ordinance" an employer could fund a defined-benefit pension by a certain dollar amount for every employee. If the employer did not meet the required minimum, it would be required to pay the difference into a state-run pension fund—just as in the current San Francisco Ordinance.

These are the logical results when pressing national problems are addressed in a newly-created regulatory field that had once been occupied explicitly and entirely by the Federal government. Some active localities will rush to the field in myriad different and conflicting ways. Employers may be forced to shift scarce resources to compliance in high cost states, rather than to the provision of uniform benefits to all employees. The result could leave employees in some states with fewer benefits or they may lose their plan altogether.

What cannot be missed is that the policy choices and substantive protections embedded in ERISA will be lost. Under the new state and locally run benefit plans, employees will no longer have the protections of ERISA. Protection of federally mandated fiduciary duties, federally guaranteed pension benefits via the Pension Benefit Guaranty Corporation, federally mandated minimum pension funding requirements, extensive benefit disclosure and claims appeal rights, and access to the federal courts will all be lost to employees. Employers will drown in a morass of overlapping, burdensome and contradictory obligations. *GGRA II*, 558 F.3d at 1009 ("If upheld, *Golden Gate* will undoubtedly serve as a roadmap in jurisdictions across the country on how to design and enact a labyrinth of laws requiring employer compliance on health care expenditures ..."). Congress rejected this scenario more than thirty-five years ago in favor of national uniformity through ERISA.

Because the Ninth Circuit's Decision effectively reads ERISA's preemption provision out of the statute, undermining employee benefits ranging from health care to retirement, timely intervention by this Court is imperative.

III. THE DECISION DIRECTLY CONFLICTS WITH SUPREME COURT PRECEDENT.

The Ninth Circuit misgauged the scope of ERISA preemption when it found that the Ordinance was not preempted because employers could comply with the law by simply writing a check to the City. *GGRA*, 546 F.3d at 660. Since compliance could occur without a mandated plan change, the panel con-

cluded that ERISA preemption was not implicated. But this reasoning misreads the scope of ERISA preemption and Supreme Court precedent because the Ordinance impermissibly "structures employers' choices with respect to their existing ERISA plans." *GGRA II*, 558 F.3d at 1007. *See also Egelhoff*, 532 U.S. at 150 (a "statute is not any less of a regulation of the terms of ERISA plans simply because there are two ways of complying with it").

In *Egelhoff*, this Court concluded that a state law automatically revoking spousal beneficiary designations upon divorce was preempted by ERISA. 532 U.S. at 150. This was so even though employers were able to opt out of the state law requirement by simply amending the plan document to state that the state's automatic beneficiary change was not effective. *Id.* at 150-51. Although a one-time plan change (or payment of benefits to the state's default beneficiary) may not have been especially burdensome, the very fact that the statute forced plans and employers to make those choices at all was objectionable, *id.* at 151, given that the statute bound plan administrators to particular state rules, *id.* at 147. Even more troublesome, as the Court recognized, allowing a state to pose such a choice strikes at the very heart of ERISA because plan administrators could be forced potentially to account for provisions in all 50 states. *Id; accord GGRA II*, 558 F.3d at 1007-1008.

The Ordinance places employers in the same box squarely rejected in *Egelhoff*. *See* 532 U.S. at 150-51. The Ninth Circuit below candidly admits that a "covered employer may choose to adopt or to change an ERISA plan in lieu of making the required health

care expenditures to the City." *GGRA*, 546 F.3d at 656. Despite this obvious "connection with" ERISA plans, the Ninth Circuit concluded that the Ordinance was not preempted because it did not *require* an employer to adopt an ERISA plan.[4] *Id.* at 655. Yet neither did the ordinance in *Egelhoff*. That statute was impermissible because under ERISA, plan administrators must follow plan documents and after the statute's passage, plan administrators could not make benefit payments "simply by identifying the beneficiary specified by the plan documents." *Egelhoff*, 532 U.S. at 148. So too, after the passage of the Ordinance, plan administrators cannot provide health benefits simply by identifying the benefits specified by the plan documents. Instead,

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[4] ERISA preemption was clearly designed to prevent states and local governments from requiring employers to establish and maintain welfare plans. In fact, the Supreme Court has not hesitated to find that state laws that require employers to offer health coverage "relate to" ERISA plans and are preempted. *Shaw*, 463 U.S. 85, 96 (1983) (New York law mandating pregnancy benefits preempted); *Dist. of Columbia v. Gr. Wash. Bd. of Trade*, 506 U.S. 125, 129-30 (1992) (District of Columbia law requiring employers to provide inactive employees on workers' compensation with the same health benefits as active employees preempted); *Local Union 598, Plumbers & Pipefitters Indus. Journeymen & Appr'ship Train'g Fund v. J.A. Jones*, 846 F.2d 1213, 1221 (9th Cir. 1988) (Washington law mandating minimum apprenticeship training funds preempted); *Agsalud v. Stnd. Oil Co.*, 454 U.S. 801 (1981), *aff'g* 633 F.2d 760 (9th Cir.) (Hawaii law mandating health benefits law preempted). *See also Aloha Airlines v. Ahue*, 12 F.3d 1498, 1505 (9th Cir. 1993) (Hawaii law requiring airlines to pay for certain medical exams preempted).

they "must familiarize themselves with state statutes so that they can determine" the appropriate and required level of benefits to provide. *Id.* at 148-49. In both cases, employers' choices are impermissibly "structure[d] . . . with respect to their existing ERISA plans." *GGRA II*, 558 F.3d at 1007. As a result, this Court should grant certiorari to find that the Ordinance is preempted by ERISA.

IV. THE COURT SHOULD CLARIFY ERISA PREEMPTION PRINCIPLES IN LIGHT OF THE IRRECONCILABLE DECISIONS OF THE FOURTH AND NINTH CIRCUIT.

Although the panel asserts that its holding does not conflict with the Fourth Circuit's conclusion in *Retail Industry Leaders Ass'n v. Fielder*, 475 F.3d 180 (4th Cir. 2007), *GGRA*, 546 F.3d at 559, the vigorous dissent to the denial of *en banc* review belies that view. *See GGRA II*, 558 F.3d at 1004. The Maryland Act required a covered employer to either spend at least 8% of the employer's total payroll for Maryland employees on health insurance costs or pay the difference to the state. *Fielder*, 475 F.3d at 184 (citing Md. Code Ann., Lab. & Empl. § 8.5-104(b)). The Fourth Circuit determined that the Maryland Act was preempted by ERISA, holding that the only rational choice a covered employer had was to modify its existing employee benefit plan because payments to the State would in no way benefit the employer's workforce. *Fielder*, 475 F.3d at 193.

In contrast, the Ninth Circuit placed great weight on its conclusion that the option to pay the City as a means of complying with the Ordinance

was a real choice because in its view the Ordinance provides benefits to employees that the Maryland Act lacked. *GGRA*, 546 F.3d at 660. But the Ninth Circuit misses the Fourth Circuit's point. The *Fielder* court did not hold that if covered employers under the Maryland Act had a real choice the law would have been saved from preemption. Rather, the *Fielder* court expressly stated that even if a covered employer had "non-ERISA health spending options to satisfy the [Maryland Act], it would need to coordinate those spending efforts with its existing ERISA plans," causing the state law to violate ERISA's preemption provision. *Fielder*, 475 F.3d at 196-97.

The *Fielder* court further grounded its decision on the fact that the Maryland Act, coupled with a proliferation of other similar laws (like the Ordinance), "would disrupt employers' uniform administration of employee benefit plans on a nationwide basis," *id.* at 194, and "manipulate health care spending to comply with them," directly running afoul of the Supreme Court's *Egelhoff* decision, *id.* at 197. The dissent to the denial of *en banc* rehearing in this case echoed the Fourth Circuit's concern, recognizing that the burden this Decision "places on employers is potentially very great" and risks "the very kind of health care expenditure balkanization ERISA was intended to avoid." *GGRA II*, 558 F.3d at 1009.

In fact, the parallels between the Maryland Act and the Ordinance are too striking to miss. Both laws establish mandated (but different) minimum spending targets for health care benefits. Both laws compel employers to make up any shortfall by mak-

ing their own plans more generous or by making payments to the government. Both laws require employers to keep new records and make myriad new reports to the government. Both laws impose penalties for noncompliance. As the dissent to the denial of *en banc* rehearing in *GGRA* succinctly stated, "[a] currently non-complying employer in San Francisco has the same choice as a non-complying employer in Maryland: Make a payment to the government or change its current ERISA plan." *GGRA II*, 558 F.3d at 1007-08. The differences between *Fielder* and *GGRA* are illusory, the cases are in irreconcilable tension, and this Court should grant certiorari to resolve the conflict.

V. THE DECISION DEPARTS FROM LONG-SETTLED LAW DEFINING ERISA PLANS.

The Decision below concedes that if the payments to the City created an ERISA plan, the Ordinance would be preempted. *GGRA*, 546 F.3d at 653. The panel, however, incorrectly concluded that the payments to the City do not create a plan that is subject to ERISA. Based on this erroneous conclusion, the court held that the Ordinance did not implicate preemption.

As the Department of Labor's amicus brief in the court below definitively and exhaustively explains, ERISA covers all employment-based pension and welfare plans. A "welfare plan" is broadly defined to include, among other things, "*any* plan, fund, or program . . . established or maintained by an employer . . . for the purpose of providing for its participants or their beneficiaries, through the purchase of insur-

ance or otherwise, (A) medical, surgical, or hospital care or benefits . . .." ERISA § 3(1); 29 U.S.C., § 1002(1) (emphasis added). "Because this definition of an ERISA 'plan' is so expansive, nearly any systematic provision of healthcare benefits to employees constitutes a plan." *Fielder*, 475 F.3d at 190-91.

Even if an employer merely purchases insurance and delegates many of the plan's administrative duties (*e.g.*, claims payment) to the insurer, an ERISA welfare plan has been created. *See, e.g., Brundage-Peterson v. Compcare Health Servs. Ins. Corp.*, 877 F.2d 509, 511 (7th Cir. 1989). An employer's plan does not even need to be established through a formal plan document; an employer's actions alone may be sufficient to constitute "establishing" a plan. *Donovan v. Dillingham*, 688 F.2d 1367, 1372-73 (11th Cir. 1982).

This expansive definition of an ERISA plan serves to protect employers and employees alike. As this Court has observed

> Congress enacted ERISA to 'protect ... the interests of participants in employee benefit plans and their beneficiaries' by setting out substantive regulatory requirements for employee benefit plans and to 'provid[e] for appropriate remedies, sanctions, and ready access to the Federal courts.' 29 U.S.C. § 1001(b). The purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans.

Aetna Health Inc. v. Davila, 542 U.S. 200, 208 (2004). In just one recent example, the Seventh Circuit preserved an employee's ERISA claim against

her employer despite the absence of a formal plan document. *Leister v. Dovetail, Inc.*, 546 F.3d 875 (7th Cir. 2008)(Posner, J.). It is difficult to see how a contract with a third-party administrator for 401(k) plan services could meet the definition of an ERISA plan, as it did in *Leister*, under the Ninth Circuit's reasoning. For instance, contrast a typical 401(k) plan with the Ninth Circuit's description of why the HAP program was not an ERISA plan: "[e]mployer payments . . . [routinely] provide only a small portion" of a 401(k) plan's funding (as with the HAP program) and 401(k) plans are administered by entities other than the employer as a matter of course (as with the HAP program). *Id.* Although the nature of HAP enrollment distinguishes it from a typical single employer 401(k) plan, a multi-employer 401(k) plan seems directly analogous to the HAP participation model. In short, it is difficult to reconcile the Seventh Circuit's *Leister* decision that an ERISA plan existed with the Ninth Circuit's cramped plan analysis. And absent an ERISA plan, Leister would have been left without a claim to benefits. *Leister*, 546 F.3d at 879.

ERISA provides participants with substantive protections and access to the federal courts, while employers receive the benefits of uniform regulatory requirements. The Ninth Circuit's unduly narrow definition of an ERISA plan threatens not only to subject employers to a patchwork of possibly conflicting requirements, but may strip employees of important federal protections regarding employer-provided health benefits.

CONCLUSION

For the reasons above, the petition for writ of certiorari should be granted.

Respectfully submitted,

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IN THE

Supreme Court of the United States

GOLDEN GATE RESTAURANT ASSOCIATION,

Petitioner,

v.

CITY AND COUNTY OF SAN FRANCISCO, et al.,

Respondent.

SAN FRANCISCO CENTRAL LABOR COUNCIL, et al.,

Intervenors/Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF OF AMICI CURIAE THE ERISA INDUSTRY COMMITTEE AND NATIONAL BUSINESS GROUP ON HEALTH IN SUPPORT OF PETITIONER

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QUESTION PRESENTED

Whether ERISA section 514(a), 29 U.S.C. § 1144(a), preempts local laws mandating ongoing employer contributions for employee health-benefits, or alternative payments to a local government, and extensive recordkeeping and reporting and disclosure requirements, a question on which the courts of appeals are in conflict.

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The ERISA Industry Committee ("ERIC") and the National Business Group on Health ("NBGH") respectfully submit this brief *amici curiae* in support of the petition for a writ of certiorari in this case.[1]

INTEREST OF AMICI CURIAE

ERIC is a non-profit corporation representing America's largest private-sector employers. ERIC's members maintain, administer, and provide services to health care plans and other employee benefit plans governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, 29 U.S.C. § 1001 *et seq.* All of ERIC's members do business in more than one State, and many have employees in all fifty States.

NBGH, formerly known as the Washington Business Group on Health, is a non-profit organization devoted to representing large employers' perspectives on national health policy issues. NBGH is the national voice of large employers dedicated to finding solutions to the nation's most important health care issues.

Together, ERIC and NBGH have well over 300 members. Millions of active and retired workers and their families receive health care benefits through employee benefit plans sponsored by ERIC's and NBGH's members.

These *amici* participate in cases with the potential for far-reaching effects on employee benefit plan design or administration, and in which they seek to present views

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[1] The parties have consented to the filing of this brief after timely notice, and their respective letters of consent have been lodged with the Clerk. S. Ct. R. 37.2. No party authored this brief in whole or in part and no person or entity other than ERIC, NBGH, or their members contributed monetarily to its preparation or submission. *Id.* 37.6.

that will not be presented by the parties or other potential *amici*.[2] ERIC and NBGH believe that this is such a case.

The Ninth Circuit's ruling in this case—that ERISA does not preempt local laws requiring employers to make expenditures for employee health care, or equivalent payments to a local government, at a specified level or higher—opens the door to a patchwork quilt of local ordinances that will prevent employers that operate and provide health care benefits in more than one state or municipality from providing uniform nationwide health care coverage for their employees. As a result of the decision, ERIC's and NBGH's members face the prospect as employers of a patchwork quilt of varied welfare plan mandates and regulations around the country.

STATEMENT

1. Although ERISA provides incentives that strongly encourage employer-provided benefit plans, nothing in the statute requires employers to establish employee benefit plans. *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996). Moreover, when an employer elects to establish an employee benefits plan, the statute allows the plan sponsor to define the benefits provided. *See id.*; *Black & Decker*, 538 U.S. at 833; *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 732 (1985); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 511 (1981).[3]

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[2] *See, e.g., LaRue v. DeWolff, Boberg & Assocs.*, 128 S. Ct. 1020, 1027 (2008) (Roberts, C.J., concurring in part and in judgment) (citing ERIC's *amicus* brief); *Gen. Dynamics Land Sys. v. Cline*, 540 U.S. 581 (2004); *Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003); *Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432 (1999).

[3] A plan sponsor's latitude to define the content of employee benefits plans is subject only to specified federal requirements (continued...)

2. Large businesses are substantially more likely than smaller firms to offer health benefits to their employees. According to a 2007 survey by the U.S. Department of Labor, among firms employing at least one hundred workers, 93% of employers offered health care benefits. By contrast, only 59% of smaller firms (with less than one hundred employees) offered some form of health care coverage to their employees. *See* U.S. Dep't of Labor, Bureau of Labor Statistics, National Compensation Survey: Employee Benefits in Private Industry in the United States, March 2007, at 15 tbl.7.[4]

Large firms like the members of ERIC and NBGH typically have employees in numerous jurisdictions. Such multi-jurisdictional employers provide a substantial percentage of all of the private health care coverage offered in the United States. *See generally id.* Large firms (with more than 5,000 employees) also are considerably more likely than small firms to sponsor self-insured health plans. William Pierron & Paul Fronstin, Employer Benefit Research Institute, *Issue Brief No. 314: ERISA Pre-emption: Implications for Health Reform and Coverage*, at 11 (2008).[5] The difference is significant because ERISA specifically exempts self-insured plans from State regulation; consequently, employers that sponsor self-insured health plans can tailor their plans to

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such as ERISA's anti-backloading rules for accrual of pension plan benefits, *e.g.*, 29 U.S.C. § 1054(b)(1)(B), and the continuance-of-benefits requirements for group health plans established by COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1986), *see id.* § 1162(2).

[4] This Labor Department report is available online at http://www.bls.gov/ncs/ebs/sp/ebsm0006.pdf (last viewed July 9, 2009).

[5] This EBRI report is available online at http://www.ebri.org/pdf/briefspdf/EBRI_IB_02a-20082.pdf (last viewed July 9, 2009).

address their employees' needs and avoid the substantial costs and administrative burdens of complying with the patchwork requirements of State insurance laws. *See* 29 U.S.C. § 1144(b)(2)(B); Pierron & Fronstin, *supra*, at 11.[6]

3. Of course, multi-jurisdictional employers are not necessarily very large corporations with operations nationwide. Smaller regional and local enterprises frequently operate in multiple municipal, county, and State jurisdictions. A business based in San Francisco may employ workers in Oakland or San Jose. Likewise, an enterprise in St. Louis, Missouri, may employ workers at sites nearby in Illinois; one based in Kansas City may have workplaces in both Missouri and Kansas. A local restaurant chain based in Washington, D.C., might employ workers, not only in the District of Columbia, but also at workplaces in Montgomery and Prince George's Counties in Maryland, the City of Alexandria, Virginia, or Arlington and Fairfax Counties in Virginia.[7]

4. ERISA preemption is essential for multi-jurisdictional employers. Under ERISA, multi-jurisdictional employers can offer a single, coordinated package of employee health care benefits to all eligible employees, regardless of where they live, where they work currently, or where they might be transferred by the employer. Through administrative efficiencies, this permits plans to

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[6] *See also* Victoria Craig Bunce & JP Wieske, Health Insurance Mandates in the States 2008 (Council for Affordable Health Ins., Alexandria, Va.), Jan. 2008 (listing state health insurance mandates and estimating effects of compliance costs), *available online at* http://www.cahi.org/cahi_contents/resources/pdf/HealthInsuranceMandates2008.pdf (last viewed July 9, 2009).

[7] Similar "local" employers with worksites in multiple municipalities, counties, or States could be found in metropolitan areas around Boston, New York City, Philadelphia, Chicago, Dallas, Los Angeles, and elsewhere.

provide health care benefits at costs that are significantly lower than they would be under a regime requiring a multi-jurisdictional employer to meet the varying mandates of each State or locality in which one or more of its employees works.

The ability to provide uniform benefits and to administer plans uniformly across jurisdictional lines facilitates the negotiation and implementation of collective bargaining agreements that cover workers in multiple municipal and State jurisdictions.

Preemption also is important to employees who benefit from a coherent system regardless of where they work, live, or obtain their health care services. Thus, an employee who transfers or relocates to a workplace in a different jurisdiction can continue to participate in the same nationwide benefit plan and can retain the same benefits that are important to him or her, particularly if the employee or a family member suffers from a disease or condition that is currently undergoing treatment. The retention of those benefits is vital to avoiding the confusion that, in the absence of a uniform plan, would inevitably arise as a result of a transfer.

Furthermore, the ability to provide uniform benefits to all eligible employees, across jurisdictional lines, also fosters employee morale and avoids inequities by allowing workers in comparable positions to receive the same benefits regardless of their locations.

5. The San Francisco Health Care Security Ordinance ("San Francisco Ordinance") requires every covered employer in the City to certify that it has made the required "health care expenditure" either directly or indirectly on behalf of every covered employee.[8] Direct

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[8] The required health care expenditure depends on the number of covered employees, and is scheduled to be adjusted (continued...)

expenditures include amounts spent to provide health care coverage via health savings accounts, reimbursement of employee expenditures, payments to third parties, and costs incurred in the direct delivery of health care to employees. Unless the employer makes such expenditures in at least the requisite amount for every covered employee, the employer must pay the difference to the City to provide health care for the employer's employees. S.F., Cal., Admin. Code § 14.1(b)(7), Pet. App. at 110a-111a; *id.* § 14.3, Pet. App. at 115a-117a.

The San Francisco Ordinance imposes related reporting and recordkeeping requirements on employers. *Id.* § 14.3(a), Pet. App. at 116a-117a. As an initial matter, the employer must identify its "covered employees." *Id.* § 14.1(b)(2), Pet. App. 107a-109a; HCSO Regs. § 3.1, Pet. App. 130a-132a. A "covered employee" is one who performs at least ten hours of work per week within the City, including the time a transient employee spends in the City performing substantive duties—*e.g.*, deliveries—and time worked by telecommuters from homes in the City. *Id.* § 3.1(A)(3), Pet. App. at 130a; *id.* § 3.1(C)(1), Pet. App. at 131a; *id.* § 6.1(C)(1)(d), Pet. App. at 140a.[9]

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annually. *See* S.F., Cal., Regulations Implementing the Employer Spending Requirement of the San Francisco Health Care Security Ordinance ("HCSO Regs."), § 5.2, Pet. App. at 138a-139a.

[9] The San Francisco Ordinance effectively obligates employers with covered employees on salary (for whom hours of work might not otherwise be tracked) to develop systems to record the hourly "work performed" information the Ordinance requires. By contrast, in implementing ERISA, the Treasury Department avoided saddling employers with such an hour-counting requirement—even for pension plans subject to ERISA's 1,000-hour rule. *See Johnson v. Buckley*, 356 F.3d 1067, 1072-74 (9th Cir. 2004) (discussing the pertinent Treasury regulations and noting that one of the primary goals of ERISA is to reduce the burden of compliance with its (continued...)

Employers also are required by the Ordinance to track their health care expenditures. *Id.* § 6, Pet. App. at 139a-142a. What constitutes a qualifying expenditure under the Ordinance is governed by the implementing regulations. *See id.* § 4, Pet. App. at 135a-137a. Apart from stating that medical expenses currently deductible under the Internal Revenue Code may be counted, *id.* § 4.1(B), Pet. App. at 135a, the HCSO Regulations merely offer examples for determining what spending does (or does not) count toward the mandatory expenditure requirement, *see id.* § 4.2(A), Pet. App. at 135a-136a; *id.* § 4.3, Pet. App. at 137a. For example, the Regulations exclude administrative expenses associated with third-party provision of health care, *id.* § 4.2(C), Pet, App. at 137a, a distinction that employers find difficult to make. The Regulations also provide that qualifying expenditures include items that are usually treated as personal expenses and excluded from coverage by many ERISA health care plans (*e.g.*, non-prescription allergy medications, cold medicines, and pain relievers). *Id.* § 4.3, Pet. App. at 137a.

The Regulations require the employer to provide a detailed account of each employee's personal information and work history, *id.* § 7.2(A)(1)-(2), Pet. App. at 143a, as well as "records [of expenditures] sufficient to establish compliance with the Employer Spending Requirements of this Ordinance, including, as applicable, records of health care expenditures made, calculations of health care expenditures required under this Ordinance for each covered employee, and proof documenting that such expenditures were made at least quarterly each year," *id.* § 7.2(A)(3), Pet. App. at 143a-144a.

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provisions by plan administrators); *Swaida v. IBM Ret. Plan*, 570 F. Supp. 482, 487-88 (S.D.N.Y. 1983) (same), *aff'd per curiam*, 728 F.2d 159 (2d Cir. 1984).

SUMMARY OF ARGUMENT

1. Establishing a regulatory regime that allows employers to provide uniform benefits and plan administration for employees nationwide was a primary congressional goal when enacting ERISA. Congress achieved that goal through ERISA section 514(a), 29 U.S.C. § 1144(a), which expressly and expansively provides for federal preemption of State laws relating to employee benefits plans. Enforcement of that preemption provision is essential so that employers will not confront a patchwork of myriad state and local regulations that would prevent them from providing uniform benefits across jurisdictional lines. The erroneous holding by the court of appeals that ERISA does not preempt the San Francisco Ordinance contravenes Congress's expressed intent and undermines its important goals.

2. The Ninth Circuit's decision created a conflict among the courts of appeals because its analysis cannot genuinely be reconciled with the reasoning of the Fourth Circuit, which held that ERISA preempted an employer health care spending mandate in Maryland. Nor is the Ninth Circuit decision consistent with this Court's jurisprudence applying ERISA section 514(a). The decision of the court of appeals in this case introduces grave confusion as to the scope of ERISA preemption, which should be addressed and corrected by the Court.

REASONS FOR GRANTING THE WRIT

I. The Ninth Circuit Decision Undermines the Statutory Goal of Allowing Uniform Plan Design and Administration by Multi-Jurisdictional Employers

The Petition in this case presents an issue of grave national importance, especially to the nation's employers that provide jobs and benefits to workers, retirees, and

their families across the land: whether Congress's objective of creating a regime of uniform regulations for employee benefit plans can be subverted by myriad local schemes that can impose varied requirements for employer-provided health care and other employee benefits to workers.

A. In section 514(a), ERISA contains one of the most expansive preemption provisions of any federal statute. Although the Ninth Circuit opinion refers to the creation of a uniform regulatory regime as *one* of the purposes of ERISA, Pet. App. at 13a, it fails to acknowledge the strength of Congress's intent to achieve that goal and also fails to give effect to that intent.

When enacting ERISA, Congress was not content to provide the basis for implicit preemption by merely occupying the regulatory field for employer-provided retirement and welfare plan benefits. Nor did Congress merely provide that any State regulation that was inconsistent with federal requirements would be preempted. Section 514(a) expressly declares that the statute preempts "any and all State laws insofar as they may now or hereafter *relate to* any employee benefit plan" covered by ERISA. 29 U.S.C. § 1144(a) (emphasis added).[10]

As Professor James Wooten observed, "preemption issues played a pivotal role in Congress's decision to pass ERISA." James A. Wooten, *A Legislative and Political History of ERISA Preemption, Part 2*, J. PENSION

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[10] This broad preemption provision is subject to limited express exceptions. *See, e.g.*, 29 U.S.C. § 1144(b)(2)(A) (state laws regulating insurance, banking, or securities are not preempted).

BENEFITS, Vol. 14, No. 3, at 5 (Spring 2007).[11] Before ERISA was enacted, employee benefit plans were regulated by a patchwork of State statutes, local ordinances, and court-made rules. An employer that provided benefits to a multi-state work force encountered severe administrative difficulties and wasteful expense as it attempted to comply with rules that differed from State to State, and sometimes from city to city. Against this backdrop, a coalition reflecting both employer and labor perspectives sought not only the protection of retirement plan assets (as the Ninth Circuit emphasized in this case), but also the establishment of a uniform regulatory regime nationwide for both retirement and welfare benefit plans. *See id.* at 10.

This Court has repeatedly recognized that one of the primary purposes of ERISA was to achieve uniformity—and, conversely, to prevent multiplicity—in employee benefits regulation. *See Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004) ("The purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans."); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990) ("Section 514(a) was intended to ensure that plans and plan sponsors would be subject to a uniform body of benefits law ...."). As the Court has noted, preemption serves the congressional goal "to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government." *Ingersoll-Rand*, 498 U.S. at 142. "A patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain

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[11] This article by Prof. Wooten is available online at http://www.law.buffalo.edu/Faculty_And_Staff/submenu/Wooten/ERISAPreemptionPart2.pdf (last viewed July 9, 2009).

from adopting them." *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987); *see also FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990) ("To require plan providers to design their programs in an environment of differing state regulations would complicate the administration of nationwide plans, producing inefficiencies that employers might offset with decreased benefits."). Congress deemed preemption necessary to encourage voluntary employer sponsorship of employee benefit plans.

As noted above, the presence—or absence—of health care benefit plans may result from collective bargaining in which the provision and content of such benefits was a significant, but not exclusive, issue for negotiation between labor and management. Preemption precludes varied State and local regulation that would hinder such collective bargaining for multi-jurisdictional workforces. This Court has recognized that the federal interest in preemption is particularly important in this context. *See Alessi*, 451 U.S. at 525.

B. ERISA's legislative history underscores the importance that legislators attached to its express preemption provision. The bills passed by the House and Senate as precursors to ERISA included a preemption provision that was much narrower than the provision that ultimately became section 514(a) of ERISA. The precursor bills would have superseded State law only in areas specifically regulated by the federal statute. In conference, however, the conferees recognized that such a provision would have only limited effect, insufficient to preclude State regulation that would hinder uniform plan design and administration. Senator Javits, one of the chief architects of ERISA, explained that the narrow preemption provision "open[ed] the door to multiple and potentially conflicting State laws hastily contrived to deal with some particular aspect of private welfare or pension benefit plans not clearly connected to the Federal regulatory scheme." He concluded that, "on balance, the

emergence of a comprehensive and pervasive Federal interest and the interests of uniformity with respect to interstate plans required—but for certain [specified] exceptions—the displacement of State action in the field of private employee benefit programs." 120 Cong. Rec. 29942 (Aug. 22, 1974) (remarks of Sen. Javits).[12]

The principal House sponsor of ERISA, Representative John Dent, was equally emphatic in describing the central importance of a broad preemption provision. Representative Dent stated:

> I wish to make note of what is to many the crowning achievement of this legislation, the reservation to Federal authority [of] the sole power to regulate the field of employee benefit plans. With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation.

120 Cong. Rec. 29197 (Aug. 20, 1974) (remarks of Rep. Dent).

The conferees understood that the broad preemption provision included in ERISA would prevent State and local governments from experimenting with employment-related health care reform. In fact, one of the reasons that the conferees expanded the preemption provision was to preclude State-by-State mandates for employer-provided health care. *See* Michael S. Gordon, *The History*

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[12] Senator Williams similarly emphasized the importance of ERISA's preemption provision. *See* 120 Cong. Rec. 29933 (Aug. 22, 1974) (remarks of Sen. Williams) (stating that the conference bill eliminated the threat of inconsistent State and local regulation of benefit plans and was intended "to apply in the broadest sense" to State or local actions with the force of law).

of ERISA's Preemption Provision and Its Bearing on the Current Debate Over Health Care Reform (1992).[13] When the conferees debated ERISA, Hawaii had recently enacted a health reform measure and California was considering similar legislation. *See Standard Oil Co. of Cal. v. Agsalud*, 633 F.2d 760 (9th Cir. 1980) (holding that the Hawaiian law enacted in 1974, mandating employer-provided health care programs, was preempted by ERISA), *summarily aff'd*, 454 U.S. 801 (1981).[14] The conferees feared that inconsistent State laws regulating health care would undermine employment-based health plans, and they recognized that the narrow preemption provision included in the precursor bills was not sufficient to protect plans from this threat. *See* Gordon, *supra*, at 29-30.

C. The Ninth Circuit's analysis, upholding the employer spending mandate in the San Francisco Ordinance, would allow a "patchwork scheme of regulation," *Fort Halifax Packing*, 482 U.S. at 11, that could vary not only among the fifty States, but among thousands of county and municipal jurisdictions. The alternative to ERISA preemption in this context would be a patchwork regime that requires multi-jurisdictional employers to adapt their policies to the disparate mandates of every locality and State that regulates

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[13] This text by Mr. Gordon, minority counsel to Senator Javits during the consideration and passage of ERISA, is reproduced in *Health Care Reform: Managed Competition and Beyond*, Employee Benefits Research Institute, Issue Brief No. 135, at 28-30 (March 1993), *available online at* http://www.ebri.org/pdf/briefspdf/0393ib.pdf (last viewed July 9, 2009).

[14] In 1982, Congress enacted a unique exception to ERISA's preemption provision to allow the Hawaiian health care law as enacted in 1974. *See* Pub. L. 97-473, Sec. 302 (passed December 1982, signed Jan. 14, 1983), *codified at* 29 U.S.C. § 1144(b)(5).

employer health care expenditures and other employer-provided benefits.

Under the San Francisco Ordinance's mandate, employers must be able to prove to the City that they have met the minimum expenditure requirement on the basis of expenditures that the local rules define as qualifying health care expenditures for covered employees. Nothing guarantees that other jurisdictions—*e.g.*, Oakland or Los Angeles or Chicago or New York—would define eligible expenditures (or covered employees) in the same way. As a result, employers would constantly need to monitor amendments to State and local laws to determine whether their health care expenditures count toward the spending requirement of each jurisdiction in which they have employees (and which employees count). This problem is inevitable once State and local regulation of employee benefits is permitted, leaving multi-jurisdictional employers functionally unable to offer a uniform, nationwide array of benefits.

A similar problem arises from diverse recordkeeping requirements. Data that the San Francisco Ordinance requires may differ substantially from the data required by other jurisdictions, and employers will be forced to attempt to meet each jurisdiction's particular requirements. The problems employers face in meeting San Francisco's recordkeeping requirements would be exponentially increased for employers doing business in multiple jurisdictions. Absent preemption of such local mandates, employers would face a maze of requirements that would divert time and resources from providing care and toward compliance with the huge administrative burden that these various ordinances would create. Many employers would find that maintaining a health plan was not worth the effort, assuming it were even possible.

D. Such concerns are not speculative. Businesses have already faced the threat of conflicting spending and recordkeeping requirements under State and county

health care laws enacted not only in San Francisco, but in Maryland, New York, Massachusetts, and Vermont, which have sought to impose spending and recordkeeping requirements markedly different from those imposed by the San Francisco Ordinance. *See, e.g., Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180, 184 (4th Cir. 2007) (Maryland legislature enacted a statute requiring certain employers to spend 8% of total wages on "health insurance costs" and to make annual reports regarding numbers of employees, "health insurance costs," and the percentage of compensation spent on "health insurance costs"); *Retail Indus. Leaders Ass'n v. Suffolk County*, 497 F. Supp. 2d 403, 406-07 (E.D.N.Y. 2007) (county enacted legislation requiring certain employers to make expenditures equivalent to the approximate cost to the public health care system of providing health care to each employee, as determined by an administrative agency). Even the small sample of laws described in published judicial decisions makes it evident that States and municipalities could take a wide variety of approaches and impose, in the aggregate, enormous recordkeeping burdens on employers.

II. The Court Should Resolve the Confusion Created by the Conflicting Decisions of Courts of Appeals Concerning Preemption of Local Laws Mandating Employer Health-Care Spending.

A. As the eight judges of the Ninth Circuit who dissented from the denial of rehearing *en banc* correctly observed, that court's panel decision cannot be genuinely reconciled with the decision of the Fourth Circuit in *Fielder*. *See* Pet. App. at 53a-55a ("The holdings of *Fielder* and *Golden Gate* stand in clear opposition"). The Secretary of Labor, in her brief as *amicus curiae* in support of the Petitioner's request for rehearing in the Ninth Circuit, likewise recognized that the panel decision

in this case "conflicts with the Fourth Circuit's analysis of the uniformity issue in *Fielder*." *Id.* at 80a.

In *Fielder*, the challenged Maryland law required certain large employers to spend 8% of their total payroll on employee health benefits or to pay the difference between the mandated amount and their actual expenditures to the State. 475 F.3d at 183. Any funds paid to the State could be used only to fund Maryland's health programs for children. *Id.* at 185. Although the San Francisco Ordinance requires the City to earmark the funds paid by an employer to provide health care to the particular employer's employees, the two laws take the same basic approach: they require the employer to choose either to spend a specified amount to provide health care directly to its employees or to pay the same amount to the State or local government.

The Fourth Circuit held that ERISA preempted the Maryland law because it left an affected employer with no rational choice other than to provide its employees with health care and thereby required the employer to alter (or create) an ERISA plan. The employer that responds to a mandate by providing the required health care benefits to its workforce can hope to receive "improved retention and performance of present employees and the ability to attract more and better new employees." *Id.* at 193. Conversely, an employer that possesses the resources to provide mandated benefits but chooses to pay the State instead gains nothing and "might suffer from lower employee morale and increased public condemnation." *Id.* Consequently, "the only rational choice employers have is to structure their ERISA health care benefit plans so as to meet the minimum spending threshold." *Id.*

From an employer's perspective, the San Francisco Ordinance upheld by the Ninth Circuit is indistinguishable from the Maryland law because it puts the employer in the same position. When economically feasible, the employer's purported choice between paying

for its own employees' health care coverage and paying an equivalent amount to the government entity is really no choice at all. *See Suffolk County*, 497 F. Supp. 2d at 417 (evaluating a similar law enacted by a New York county and holding that "it is unreasonable to expect employers to contribute to the community or directly to the state, rather than to their own employees"). By far the most—and perhaps only—rational decision for an employer that can shoulder the administrative burden is to meet the San Francisco Ordinance's spending mandate by establishing an ERISA health care plan, thus forcing it to do what Congress in ERISA specifically sought to avoid.

B. Nor can the Ninth Circuit decision be reconciled with the precedents of this Court construing the reference in section 514(a) to State or local laws that "relate to" employee benefit plans. A law relates to an ERISA employee benefit plan for purposes of section 514(a) "if it [1] has a connection with or [2] reference to such a plan." *California Div. of Labor Stds. Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 324 (1997) (internal quotation marks omitted).[15] In this case, the San Francisco Ordinance has an impermissible relation under either prong of the analysis.

As the Ninth Circuit acknowledged, the amount that the San Francisco Ordinance requires an employer to pay the City depends on whether, and to what extent, an employer is making expenditures in connection with and in reference to an ERISA welfare benefit plan.

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[15] In determining if other state laws had an impermissible "connection" with ERISA plans, the Court has looked to both (a) the objective of ERISA as a guide to the state laws that Congress understood would survive and (b) the nature of the effect of the state law on ERISA plans. *See Dillingham*, 519 U.S. at 325; *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656-59 (1995).

Businesses that sponsor ERISA health care plans whose scope of coverage and qualifying costs make those employers "Full High Coverage Employers"—to use the Ninth Circuit's phrase, Pet. App. at 10a—owe the City nothing under the San Francisco Ordinance.[16] Yet employers that sponsor ERISA plans that entail less costs than the City's spending mandate, or whose plans do not cover all required employees—"Full Low Coverage Employers" and "Selective High Coverage Employers," *id.* at 10a-11a—must pay amounts to the City that are determined by the shortfall between their costs or coverage and the San Francisco Ordinance's mandate.

Consequently, the financial obligation imposed by the Ordinance on an employer in San Francisco is directly "connected with" any ERISA health care plan that the employer has chosen to sponsor. Although the Ordinance scrupulously avoids using words such as "employee benefit plan," "welfare plan," or "group health plan," its definition of "health care expenditure" (Pet. App. 110a) encompasses the costs to employers of providing and administering such ERISA plans and thus refers to such plans in determining the quantum of the payment due, if any, to the City.

C. The Ninth Circuit opinion undermines ERISA's preemption goals by emphasizing another congressional objective: to protect against misuse of benefit plan assets. *See Golden Gate Restaurant Ass'n v. City of San Francisco*, 546 F.3d 639, 649 (9th Cir. 2008) (referring to "the first underlying purpose of ERISA"), *reh'g & reh'g en*

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[16] Those employers nonetheless are required to comply with reporting and recordkeeping requirements of the San Francisco Ordinance.

banc denied, 558 F.3d 1000 (2009).[17] That purpose, however, is neither inconsistent with nor of greater importance than Congress's intent to broadly preempt patchwork State regulation of employer-provided benefit plans, including health care and other welfare benefit plans.[18]

Given employer health care mandates that already have been enacted in multiple jurisdictions, and the presence of the Ninth Circuit's decision as a putative roadmap for State, county, and local governments to follow, the conflict among the decisions of the courts of appeals promises to engender recurring controversy and litigation. That conflict is ripe for resolution by the Court at this time.

D. Finally, the *amici* note that the current Congress has begun the process of considering federal legislation aimed at expanding the availability and lowering the costs of health care in this country. Contrary to the City's assertion in its response to the Petitioner's request for a stay of the court of appeals mandate,[19] this circumstance

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[17] It appears that this portion of the text of the Ninth Circuit decision was inadvertently omitted from the Appendix to the Petition.

[18] The Ninth Circuit's decision also circumvents congressional intent regarding preemption by relying, in part, on the assertion that ERISA was not intended to preempt either State regulation of heath care providers or governmental provision of health care services to persons with low or moderate incomes. Pet. App. at 14a. In doing so, the opinion relies on a sleight-of-hand that leaps from traditional State regulation of health care services and State agencies' delivery of health care to the public (both allowed by ERISA) to State-imposed mandates that *employers* provide health care benefits (preempted by ERISA).

[19] *See* Docket No. 08A824, Joint Response to Application for Order Staying Mandate and Vacating Stay of District Court Judgment, at 25-26.

increases, rather than diminishes, the need for correction of the Ninth Circuit's erroneous decision. All the significant health care reform proposals currently under discussion are similar in at least one respect: they give credence to and depend upon the continuing participation of employers as vital sponsors of benefits providing access to health care. Enforcement of ERISA's preemption provision is essential to that goal; conversely, as the framers of ERISA recognized, a balkanized legal environment could be fatal to it.

CONCLUSION

For the foregoing reasons, the *amici* respectfully ask this Court to grant a writ of certiorari to resolve the important question presented herein.

Respectfully submitted,

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July 2009

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(9)

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IN THE

Supreme Court of the United States

GOLDEN GATE RESTAURANT ASSOCIATION,
Petitioner,

v.

CITY AND COUNTY OF SAN FRANCISCO,
Respondent,

SAN FRANCISCO CENTRAL LABOR COUNCIL; SERVICE EMPLOYEES INTERNATIONAL UNION ("SEIU"), LOCAL 1021; SEIU UNITED HEALTHCARE WORKERS-WEST; AND UNITE HERE! LOCAL 2,
Intervenor/Respondents,

On Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF OF *AMICUS CURIAE* NIBBI BROS. ASSOCIATES, INC. IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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INTERESTS OF THE *AMICUS CURIAE* [1]

Amicus Curiae Nibbi Bros. Associates, Inc. ("Nibbi Brothers") is a privately-owned general contractor that has been in operation in the greater San Francisco Bay Area since 1950. From a small shop in the South of Market district of San Francisco, Nibbi Brothers has grown to be the 13th largest contractor in the Bay Area. Nibbi Brothers is a dedicated team of construction professionals who genuinely care for the communities in which they live and work. Nibbi Brothers employs carpenters and laborers on a job-by-job basis, resulting in a highly transitory and seasonal workforce. The company's projects have ranged over seven counties, and it is required to comply with numerous city and county ordinances in these diverse jurisdictions. As such, the company has great familiarity with the procedures required to monitor and comply with the employment laws of multiple jurisdictions.

Nibbi Brothers fully supports the goals of the San Francisco Health Care Security Ordinance ("HCSO") and the benefits it has already accorded to individual employees and the community in general. Nibbi Brothers presents this brief to counter the hyperbolic presentation of the Petitioner and its *amici* who

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[1] Nibbi Brothers has obtained the written consent of all the parties to file this brief with the Court. Counsel of record for all parties received notice at least 10 days prior to the due date of the amicus curiae's intention to file this brief. Pursuant to Supreme Court Rule 37.6, the Amicus notes that no counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than amicus curiae, its members, or its counsel made a monetary contribution to its preparation or submission.

insist, with no record evidence whatsoever, that complying with laws like the HCSO is somehow a Herculean task. With modern computer systems, standard business and accounting practices, and a little rational planning, adjusting to the varying rules in different jurisdictions takes only a nominal effort. Indeed, it is no more difficult to comply with the HCSO than it is to comply with diverse prevailing wage laws that have been consistently found not preempted by ERISA, or with negotiated contracts that require different wage terms in different areas.

In addition, as a responsible employer that provides health care for its workers, Nibbi Brothers has an interest in not being at a competitive disadvantage when dealing with employers who choose not to bear any of that societal cost. One of the purposes of the HCSO is to "prevent[] a 'race to the bottom' in which employers stop paying for employee health care to remain competitive . . . ." Resp. App. 64-65 (SF Admin. Code Ch. 14 §1); *see also WSB Electric, Inc. v. Curry*, 88 F.3d 788, 794 (9th Cir. 1996) (noting concern that contractors who provide fringe benefits may not be able to effectively compete against contractors who provide only cash wages). Nibbi Brothers has a competitive interest in avoiding a "race to the bottom," and San Francisco's HCSO is a rational means of promoting that legitimate governmental purpose.

SUMMARY OF ARGUMENT

The petition for *certiorari* should be denied for three reasons:

First, the Ninth Circuit correctly held that the HCSO is not preempted by ERISA because it has, at most, an indirect and voluntary impact on ERISA

plans. In this regard, the HCSO is functionally indistinguishable from prevailing wage and living wage laws that have universally been found *not* preempted by ERISA.

Second, the circuit split Petitioner attempts to manufacture does not exist. The Fourth Circuit's decision in *Retail Industry Leaders Association v. Fielder*, 475 F.3d 180 (4th Cir. 2007), is wholly consistent with the Ninth Circuit's decision in *Golden Gate Restaurant Association v. City and County of San Francisco*, 546 F.3d 639 (9th. Cir. 2008) ("*GGRA II*"). Both cases recognize that state and local laws can have incidental impacts on ERISA plans without triggering ERISA preemption as long as they do not force employers to adopt or change ERISA plans.

Third, Petitioner's argument that compliance with the HCSO and hypothetical similar laws would overwhelm employers and ERISA plans simply has no factual basis. Compliance with the HCSO by employers is straightforward and requires nothing more than the sensible business steps already necessary to work across jurisdictions. Indeed, compliance with the HCSO is no more burdensome than compliance with standard terms in negotiated construction contracts or with the prevailing wage/living wage laws discussed above. While some industries may not have chosen to engage in the same payroll accounting practices, their prevalence in the construction industry and prevailing wage laws demonstrates the commercial feasibility of applying different pay standards to workers, even the same workers, across different jurisdictions. As for ERISA plans, the HCSO imposes no requirements on them whatsoever.

ARGUMENT

I. THE HCSO IS NOT PREEMPTED BY ERISA

The Ninth Circuit held that ERISA does not preempt the health care spending requirement of the HCSO because (1) it does not create an ERISA plan, (2) it has no prohibited "connection to" ERISA plans, and (3) it does not have a forbidden "reference to" ERISA plans. *GGRA II*, 546 F.3d at 648-59. Although Respondent's opposition fully addresses these points, Nibbi Brothers presents this additional argument because of Nibbi Brothers' interest and experience in dealing with prevailing wage and other employment laws across various jurisdictions.

As this Court is aware, numerous jurisdictions have enacted prevailing wage laws that regulate the wages paid to workers performing tasks under government contracts and/or living wage laws that apply to work performed in a given jurisdiction. Those regulations (like minimum wage laws) vary substantially from jurisdiction to jurisdiction, and it is incumbent on a business like Nibbi Brothers that performs work across jurisdictions to remain informed about changes in those laws so that it can comply with them.

Prevailing/living wage laws typically set a mandatory minimum pay structure that is higher than the local, state, or federal minimum wage. The prevailing/living wage laws also commonly allow employers to pay some of the mandatory wage in benefits rather than directly as wages. In the San Francisco Bay Area where Nibbi Brothers operates, for example, the City of Oakland requires certain employers to contribute $1.25/hour toward health benefits or pay an

additional $1.25/hour in wages above the minimum wage. Oakland, Cal., City Charter art. VII, § 728 & Mun. Code § 2.28.030 (2008). In Berkeley, which borders Oakland to the north, similar employers contribute $1.62 per hour toward health benefits or pay additional $1.62/hour in wages. Berkeley, Cal., Mun. Code §§ 13.27.030, 13.27.050 (2009). Similar laws exist throughout California,[2] and the rest of the United States.[3]

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[2] *See, e.g.*, Port Hueneme, Cal., Mun. Code § 2561.2 (2009) (living wage of $9.35/hour with health benefit plan or $11.85/hour without); Sacramento, Cal., City Code § 3.58.03 (2009) (two schedules of minimum living wage payments depending on whether at least $1.50/hour is spent on health benefits); San Buenaventura, Cal. (Ventura City), Ordinance Code § 2.525.150 (2009) (living wage of $12.50/hour without health benefits or $9.75/hour with at least $2.75/hour of medical benefits); Santa Barbara, Cal., Mun. Code §§ 9.128.010, 9.128.020 (living wage of $14/hour without specific benefits or $12/hour with); Sebastopol, Cal., Mun. Code § 2.72.060 (2009) (crediting the "actual amount" spent on any health benefits to the living wage); Sonoma, Cal., Mun. Code § 2.70.060 (2009) (crediting health benefit payments to living wage); Ventura County, Cal., Mun. Code § 4954 (2009) (mandating living wage of $8/hour with health benefits or $10/hour without).

[3] *See, e.g.*, Nev. Const. art. XV, § 16; Albuquerque, N.M., Code of Ordinances § 13-12-3 (2009); Bernalillo County, N.M., Ord. No. 2006-26 (to be codified) (2006); Santa Fe, N.M., City Code § 28-1.5(B) (2009); Miami, Fla., Charter and Code § 18-556 (2009); Bloomington, Ind., Mun. Code § 2.28.030 (2005); Lawrence, Kan., Econ. Dev. Goals, Process and Procedures §§ 1-2112, 1-2113 (2009); Detroit, Mich., Code § 18-5-83 (2008); Lansing, Mich., Codified Ordinances § 206.24 (2008); Lincoln, Neb., Mun. Code § 2.81.030 (2009); Albany, N.Y., Code § 42-161 (2008); Nassau County, N.Y., Misc. Laws, tit. 57 (2008); New York, N.Y., Admin. Code § 6-109(b) (2002); Syracuse, N.Y., Rev. Gen. Ordinances § 50-3 (2005); Dayton, Ohio, Code of Ordinances § 35.71 (2009); Lakewood, Ohio, Admin. Code § 113.02 (2008).

Petitioner argues that it is somehow improper for an employer to be required to stay informed about changes in the law in jurisdictions where it operates. Employment is a highly regulated sphere, and laws governing innumerable aspects of the employment relationship are constantly changing. Any multi-jurisdictional employer must properly stay informed about, and in compliance with, those myriad laws. The uniformity encouraged by ERISA does *not* relate to an employer's obligations per se, but to those of a *plan administrator*. Unlike employers, ERISA plan administrators need to rely on a relatively static and uniform set of rules concerning *how to administer the plan*. *See Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9-11 (1987) (recognizing Congressional interest in "establish[ing] a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits.") *Employers*, by contrast, must reasonably expect to shift their conduct—including their labor costs—according to changes in diverse local employment laws.

Nibbi Brothers and others who perform government contract work or other qualifying work within a living wage jurisdiction are thus required to keep track of where their employees are working, what they are being paid, and what is provided in terms of benefits in order to comply with local laws. Performance under public works contracts typically requires the contractor to certify compliance with these laws, and to provide detailed accountings on a regular basis to prove compliance. The certifications Nibbi Brothers regularly provides to show compliance with prevailing wage laws are far more frequent and detailed than those required by the HCSO (which only requires a single-page yearly report). Pet. App. 144a (OLSE Reg. No. 7.3).

Prevailing/living wage statutes are not preempted by ERISA. In *California Division of Labor Standards Enforcement v. Dillingham Construction*, 519 U.S. 316 (1997), this Court rejected the claim that California's apprenticeship prevailing wage law was preempted by ERISA because it "made reference to" ERISA plans. Recognizing the prevalence of prevailing wage statutes, the Court held that a statute which "alters the incentives, but does not dictate the choices, facing ERISA plans" is *not* preempted by ERISA, and that Congress had no intention of preempting traditional areas of state regulation like wage ordinances. *Id.* at 334. The Circuit Courts have also consistently upheld wage ordinances that give credit for health benefits. *Burgio and Campofelice, Inc. v. New York State Dept. of Labor*, 107 F.3d 1000, 1009 (2d Cir. 1997); *WSB Electric, Inc.*, 88 F.3d at 793-94; *Keystone Chapter, Assoc. Builders and Contractors, Inc. v. Foley*, 37 F.3d 945, 960-61 (3d Cir. 1994).

Prevailing/living wage laws do not impose any plan administration duties. Such laws do not establish what benefits must be provided, do not set any standard of care for providing or administering plans, and do not otherwise interfere in any way with the operation of benefit plans. Nor do these laws *require* any employer to offer an ERISA benefits plan. Instead, these ubiquitous laws function as either a minimum wage or a tax, while allowing employers the opportunity for a credit against that minimum wage or tax if they choose to provide employee benefits with an ERISA plan or otherwise.

San Francisco's HCSO functions in precisely this manner: as a minimum wage/tax based on hours worked within the City. Employers must pay the required amounts to the City unless they already

make sufficient payments to offset their HCSO obligation. No employer is required to have an ERISA plan, but if they choose to, then they can claim credit for its cost. Any shortfall can be paid to the City in cash or through other appropriate expenses, which need not be ERISA plan expenses. Pet. App. 135a-137a (OLSE Reg. No. 4.2).

San Francisco's ordinance would plainly not be preempted by ERISA if it required all employers to pay the required amounts to the City *without* recognizing a credit for the cost of employer-provided health benefits. Allowing (but not requiring) employers to claim a credit against their HCSO obligation does not transmogrify an otherwise unassailable ordinance into one preempted by ERISA. In this manner, the HCSO is functionally indistinguishable from the prevailing wage law approved in *WSB*:

> [A]though the law may cause employers to maintain a separate administrative scheme to keep track of prevailing wage data for public works projects, it does not require that they maintain a separate employee benefit plan. They may choose to do so if they want to ensure that they contribute no more to employee benefits than the maximum credited under the excess benefit cap. But they are not required to do so. If their benefit contributions fall below the prevailing benefit rate, then they can make up the shortfall with cash wages, which would have no effect on their ERISA plans.

WSB Electric Inc., 88 F.3d at 795.

As with prevailing/living wage laws, the HCSO "does not force employers to provide any particular employee benefits or plans, to alter their existing

plans, or to even provide ERISA plans or employee benefits at all." *Id.* at 794. An employer can fully comply with the HCSO without having any ERISA plan. The Ninth Circuit correctly found that the same analysis applied to prevailing/living wage laws applies equally to the HCSO, and thus the HCSO is not preempted by ERISA.

II. *FIELDER* IS CONSISTENT WITH *GGRA II*

Contrary to Petitioner's arguments, the Fourth Circuit's decision in *Retail Industry Leaders Association v. Fielder*, 475 F.3d 180 (4th Cir. 2007) is entirely consistent with the above analysis. Although Petitioner and its *amici* attempt to lump these two cases together as "pay or play" decisions, the law challenged in *Fielder* was substantially different from the HCSO. *Fielder* involved a *sui generis* attempt by the State of Maryland to force Wal-Mart to provide a higher level of ERISA benefits to its employees. *Fielder*, 475 F.3d at 183. The law was *solely* directed at Wal-Mart, a fact repeatedly emphasized in the Court's opinion. *See id.* at 183, 184, 185, 194. The Maryland law required Wal-Mart to spend at least 8% of its payroll on health insurance for its employees or pay the difference to a state fund where it would offset Maryland's general Medicaid and children's health insurance budget. *Id.* at 184-85.

Fielder determined (by a 2-1 decision) that the Maryland law was intended to, and rationally could only, operate by forcing Wal-Mart to increase its ERISA spending. The Court found that no rational employer would do otherwise given the law's choices because payments to the State general fund do not benefit the employer's workers. *Id.* at 193. It also found that the Maryland legislature was aware of

this reality, and did not anticipate receiving *any* revenue from the act. The Court thus characterized any money collected by the state as a fee or penalty, not a tax. *Id.* at 189. Given these unique circumstances, the Fourth Circuit determined that the challenged law was a backdoor way of forcing Wal-Mart to increase ERISA spending, and thus preempted by ERISA. *Id.* at 195-97.

The HCSO could not be more different. It is not directed at one employer, or even only huge employers, but reaches medium and large employers across all industries in San Francisco. Pet. App. 109a, 112a (SF Admin. Code §§ 14.1(b)(3) & (12)); Pet. App. 128a-129a (OLSE Reg. No. 2.2). The City pay option is not an unrealistic or irrational penalty, and is not designed to force employers to change their ERISA benefit plans (or to create any such plan). Employers who already provide health insurance for their workers are unlikely to owe any additional money, as the average cost of health insurance is well above the City payments required by the HCSO, and thus employers with ERISA plans will, in most cases, receive a full credit for the HCSO amounts owed. Employers who do not offer health insurance are *not* required to provide it, but only to pay the City the per-hour assessment or make other non-ERISA expenditures. Pet. App. 135a-137a (OLSE Reg. No. 4.2). Unlike Maryland's law, the money is not used for a general public assistance budget; instead the payments are used to fund health care for the employees whose work led to the payments. Pet. App. 113a-115a (SF Admin. Code § 14.2).

The Ninth Circuit correctly analyzed these facts, concluding that San Francisco's law is materially different than the anti-Wal-Mart legislation at issue

in *Fielder*. As discussed above, the correct analogy is to a tax/credit or prevailing wage law which is fully consistent with *Fielder* and not preempted by ERISA. Any contrary ruling would have necessarily called into question the validity of previously upheld prevailing/living wage laws across the country, which have the same remote and indirect connection to ERISA plans as the HCSO.

III. MULTI-JURISDICTIONAL COMPLIANCE WITH LAWS LIKE THE HCSO IS NOT BURDENSOME

Finally, Petitioner and several of its *amici* make broad, unsupported parade of horribles arguments contending that the HCSO is difficult to comply with, and an unmanageable nightmare for a multi-jurisdictional employer. After inventing a hypothetical world where there is a "bewildering mismatch of employer contribution rules," Petitioner goes so far as to claim that "[c]ompliance with varying employer contribution formulas and data-compilation and administrative rules will overload the largest human resources departments and the most expensive software-systems." Pet. 38. With respect, such histrionics are empty rhetoric. Nibbi Brothers *is* a multi-jurisdictional employer with a highly variable workforce—precisely the type of employer supposedly threatened by the HCSO—yet Nibbi *does* comply with the HCSO as well as the laws of many other jurisdictions with no significant administrative effort. Compliance with this type of law is far easier than Petitioner and its allies contend.

A. Calculation of the Payments Owed is Simple

In order to comply with the HCSO, an employer needs to know (1) who its employees are, (2) when they are working in San Francisco, (3) how many hours they worked in San Francisco, and (4) what amount, if any, was paid for a health care expenditure to or for that employee. Each of these are things an employer should know in the general course of business, and which are readily tracked by any modern payroll software.

Employers with more than 20 employees obviously should know who those employees are. They are required, at least in California, and Nibbi Brothers suspects in all states, to keep records of the hours those employees work. *See* Cal. Lab. Code § 226 (2009). If employees work at fixed work sites, their employer should easily know which are working in San Francisco and which are not. Whether a restaurant, construction site, office building, etc. is within City limits is not hard to figure out. Only the tiny fraction of workers, like truck drivers, whose jobs are mobile would require any special record keeping, and they could simply record when they are within the City limits.[4]

Of course, if an employer sets up its payroll system without competent records, or with no regard to what records may be required by the jurisdictions in which it operates, then there may be start up costs associated with properly tracking the required data. The

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[4] Truck drivers are already often subject to record keeping requirements that mandate they track their location and activities on a detailed hourly basis. *See, e.g.*, 49 C.F.R. § 395.8 (2009).

purported concern here, however, is with large employers who operate across numerous jurisdictions. Such employers are highly likely to have appropriate software programs that track employee hours, pay, and benefits, or to contract with a third party payroll service, like ADP, to keep such records for them. Nibbi Brothers has such a computer system, and it takes virtually no effort at all to reprogram it to take into account various formulas required by different jurisdictions.

Once the necessary data points are collected, calculating the baseline obligation under the HCSO is simply basic algebra. For each covered employee[5] who has been employed for more than 90 days, the employer need only multiply hours worked (up to a maximum) by the applicable hourly rate (currently $1.23 or $1.85 depending on the employer's size). Pet. App. 138a-139a (OLSE Reg. No. 5.2(B). There is nothing complicated about it.

Petitioner claims that it is somehow challenging to apply different formulae in various jurisdictions.[6]

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[5] Like virtually any wage law, the HCSO exempts certain types of employees, including managerial, supervisorial, or confidential employees, from its coverage. Pet. App. 132a-135a (OLSE Reg. No. 3.2). Petitioner vaguely claims such determinations may be burdensome, but makes no attempt to explain why these determinations—which need to be made regularly to comply with minimum wage, overtime, and other types of federal and state wage and hour laws—create any new burden for employers, much less ERISA plans.

[6] Petitioner makes no showing of what formulae it is worried about, or how a slightly different mathematical formula in different jurisdictions is any harder to implement than varying minimum wages, prevailing wage laws, expense reimbursement rules, workers' compensation and unemployment insurance

That simply makes no sense. The whole point of a computerized payroll database is to allow different calculations to be run across the data. There is no reason that employers cannot code hours worked based on the location of the work, and then program their computers to apply the applicable formula to hours worked in each location. Employers too small to do so are unlikely to work across jurisdictions, but if they do they can hire a competent payroll service or otherwise structure their time keeping to reflect where work occurred.

Once the baseline expense obligation is determined, the employer applies its credits for existing expenditures to determine what additional amount, if any, is owed to the City. For employers who do *not* provide employee health benefits, this step is essentially non-existent, and they need only pay the City the required baseline amounts. Such an employer's desire not to pay the required amounts is, of course, irrelevant to ERISA preemption. The debate over whether employers should be required to pay for health care in one form or another—which in all candor appears to be the real objection Petitioner and its *amici* have to the HCSO—is a policy matter for the legislature, not a question of law for the judicial branch. It is ironic that ERISA, a statute intended to *promote* the provision of employment benefits by employers, 29 U.S.C. § 1001, is being trumpeted as creating some type of immunity from any obligation to pay for society's health care costs. ERISA is, at a minimum, agnostic about this topic; nothing in existing ERISA case law supports the notion that the government may not tax employers for the purpose of

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rates, or the myriad other payroll laws that vary across localities and contracts.

funding public health initiatives. As this Court noted in *Fort Halifax Packing Co.*, "ERISA's pre-emption provision does not refer to state laws relating to 'employee benefits,' but to state laws relating to 'employee benefit *plans*.'" 482 U.S. at 7.

As for employers who do provide benefits, the suggestion that a competent employer does not know what its benefits cost is hard to understand. If the benefits are provided according to a uniform plan, the employer can use an average cost to comply with the HCSO and need not look employee by employee.[7] Pet. App. 141a (OLSE Reg. No. 6.2(B)(1)). Given that the average cost of benefits exceeds the City's mandatory expenditures, almost all such employers will owe nothing further.

If the benefits are provided in a non-uniform manner (i.e. on an individual basis), then the employer's existing business records should reveal the relevant expenses for each employee. Taking a credit for these expenses in this context is no more difficult than seeking an income tax deduction for the same expenses, so unless an employer is providing benefits but not seeking the tax deduction to which it is entitled (a virtual impossibility) there should be no incremental burden in calculating what, if anything, the City is owed.

Nibbi Brothers is in a strong position to evaluate Petitioner's claims—it is precisely the type of multi-jurisdictional employer with changing worksites and a highly variable workforce that would be most impacted by differing standards across jurisdictions. Indeed, Nibbi has long experience dealing with this

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[7] Self-insured employers can comply in the same average-expense fashion. Pet. App. 141a (OLSE Reg. No. 6.2(B)(2)).

type of jurisdictionally-based, per-employee accounting. Nibbi Brothers' employees' wages are governed by master agreements between the relevant unions and Nibbi Brother's Contractors' Association, the Construction Employers' Association. The standard formula for employee pay in such contracts requires an hourly wage and hourly fringe benefit payments. For example, the Northern California Carpenters master contract requires separate hourly amounts for wages, health and welfare, pension, vacation, work fees, training, and annuity payments. The amounts may vary depending on the location of the job. Nibbi Brothers understands that a similar pay structure is used in most construction contracts nationwide. Complying with these master agreements requires Nibbi Brothers to record, for each employee, when that employee worked, where the job was, the number of hours, and then to apply the various line item formulas to that data—precisely the type of calculation required by the HCSO.

Of course, there are innumerable differences between ordinary employment and a union contract. The point, however, is that location-specific pay differentiation is commonly and regularly negotiated at arms-length between industry groups and unions. If it was commercially impractical—if complying with such varying standards would "overload the largest human resources departments and the most expensive software-systems" as Petitioner claims—then such requirements would *not* be commonly and freely undertaken by employers. That they are demonstrates the *lack* of any significant burden. Contrary to Petitioner's insistence, there is simply no reason even a fairly rudimentary human resources/payroll system would be "overloaded" or "overwhelmed" by laws like the HCSO.

B. The Record Keeping and Reporting Requirements Are Simple

As with calculating the amounts owed, record keeping and reporting under the HCSO are very simple and bear no resemblance to the logistical nightmare imagined by the Petitioner. The HCSO requires employers to maintain very few records, and frankly they are records that any employer should maintain anyway. First, employers are required to maintain *the same* pay records that California state law already requires. Pet. App. 143a (OLSE Reg. No. 7.2(A)(1)). Complying with pre-existing state law is in no way burdensome.

Second, the employer is required to have the address, telephone number and first day of work of all employees. Pet. App. 143a (OLSE Reg. No. 7.2(A)(2)). Again, all but the telephone number is already required to be maintained by law,[8] and any ordinary personnel file or database would include the employee's phone number.

Third, the employer must have records showing compliance with the Ordinance. No specific form of record is required. Pet. App. 143a (OLSE Reg. No. 7.2(A)(3)). As discussed above, compliance is easily measured based on the records most employers keep, so only a small amount of effort would be required to document that compliance.

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[8] The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 requires all States and the federal government to establish databases requiring employers to report the name, address, social security number and start date of all new employee hires or re-hires. 42 U.S.C. § 653a (2009); Cal. Unemp. Ins. Code § 1088.5 (2009).

Finally, any waivers signed by employees, and any notices to the employees of payment to the City, must be maintained. Pet. App. 144a (OLSE Reg. No. 7.2(A)(4)-(5)). Here too, ordinary personnel file practices would include retention of these documents in any event.

Neither Petitioner nor any of its *amici* provide any explanation for their contention that these record keeping requirements are burdensome, confusing, or even that they require anything in excess of what employers maintain in the ordinary course of business. Nibbi Brothers, for example, fully complies with the HCSO through use of records it was maintaining long before the ordinance was enacted. There is no record evidence of any employer having to incur meaningful additional expenses to comply with the HCSO's record keeping requirements, much less a showing of the crushing burden claimed by Petitioner.

As for the annual reporting requirement, it too is extraordinarily simple. The City provides a single page form to list the number of employees in various categories per quarter, total hours (not per person hours), and relevant overall spending amounts (not per-person spending).[9] The form is in no way burdensome.

At bottom there simply is no basis for the Petitioner's insistence that the HCSO's record keeping and reporting requirements are burdensome to employers. To the contrary, they simply require the type of ordinary data collection in which any modern business should already have been engaged as a matter of due course.

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[9] *See* http://www.sfgov.org/site/olse_page.asp?id=99346.

C. None of These are Obligations of the ERISA Plan Administrator In Any Event

Finally, and most importantly for ERISA preemption purposes, none of the recordkeeping or reporting requirements are imposed on ERISA plans or plan administrators. The HCSO's requirements uniformly apply to *employers* irrespective of whether they sponsor ERISA plans. No ERISA plan administrator is required to do anything under the HCSO. These *employer* reporting requirements no more affect ERISA plans than an employer's right under state (and federal) income tax law to deduct health care premiums by reporting those premiums on its tax returns.

Thus, there is absolutely no record basis or, we submit, basis in reality, for the alleged fear that the Ninth Circuit's decision in *GGRA II* will result in administrative burdens or confusion for multi-jurisdictional employers. Indeed, Nibbi Brothers' experience shows that no such burdens exist. Nibbi Brothers believes that analysis of important legal questions should be based on a developed evidentiary record, not on whatever wild speculation and worst case scenarios political opponents of a creative new solution are able to dream up. In evaluating the petition before the Court, Nibbi Brothers respectfully requests that the Court disregard the unsupported and unexplained generalizations presented by Petitioner and its *amici* concerning the supposed burden created by laws like the HCSO.

CONCLUSION

San Francisco's Health Care Security Ordinance is a creative legislative attempt to broadly distribute the cost of health care for the area's uninsured. The Ninth Circuit correctly determined that the ordinance is not preempted by ERISA, and the petition for *certiorari* should be denied.

Respectfully submitted,

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IN THE

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GOLDEN GATE RESTAURANT ASSOCIATION,
Petitioner,

v.

CITY AND COUNTY OF SAN FRANCISCO, *et al.*,
Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

BRIEF FOR THE RETAIL INDUSTRY LEADERS ASSOCIATION AND THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

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QUESTION PRESENTED

"The purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans. To this end, ERISA includes expansive pre-emption provisions, see ERISA § 514, 29 U.S.C. § 1144, which are intended to ensure that employee benefit plan regulation would be 'exclusively a federal concern.'" *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004) (internal citation omitted). In the decision below, the Ninth Circuit upheld the San Francisco Health Care Security Ordinance, which requires employers to spend specific minimum amounts on employee health care or else pay an equivalent amount to the City of San Francisco. The Ordinance applies only to employees who work within a discrete geographic area and forces employers to create, maintain, and disclose individualized records on covered employees.

The question presented is whether ERISA § 514, 29 U.S.C. § 1144, which was designed to ensure nationwide, uniform administration of employee benefit plans, preempts state or local laws that mandate minimum employer contributions for employee health care, and dictate recordkeeping, reporting, and disclosure requirements associated with those contributions.

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BRIEF FOR THE RETAIL INDUSTRY LEADERS ASSOCIATION AND THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

INTEREST OF *AMICI CURIAE*[1]

The Retail Industry Leaders Association ("RILA") is an international alliance of employers, including retailers, product manufacturers, and service providers, that promotes consumer choice and economic freedom through government advocacy and industry leadership. Its members, which include the largest and fastest-growing retail companies in the industry, account for over $1.5 trillion in annual sales, provide millions of jobs, and operate more than 100,000 stores, manufacturing facilities, and distribution centers both domestically and globally.

The Chamber of Commerce of the United States of America (the "Chamber") is a nonprofit corporation and is the world's largest business federation. The Chamber represents an underlying membership of more than three million companies and professional organizations of every size, in every industry sector, and from every region of the country. An important function of the Chamber is to represent the

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[1] Pursuant to this Court's Rule 37.2(a), counsel of record received timely notice of *amici*'s intent to file this brief, and letters of consent from all parties to the filing of this brief have been submitted to the Clerk. Pursuant to this Court's Rule 37.6, *amici* state that this brief was not authored in whole or in part by counsel for any party, and that no person or entity other than *amici* or their counsel made a monetary contribution to the preparation or submission of this brief.

interests of its members in matters before Congress, the Executive Branch, and the courts. To that end, the Chamber regularly files *amicus curiae* briefs in cases raising issues of vital concern to the Nation's business community.

RILA and the Chamber are both committed to protecting their members' ability to establish and administer health plans on a uniform, company-wide basis, and therefore oppose laws such as the San Francisco Health Care Security Ordinance that conflict with the federal policy embodied in ERISA. RILA was the plaintiff in two previous cases involving similar laws that were struck down by the courts. *Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180 (4th Cir. 2007); *Retail Indus. Leaders Ass'n v. Suffolk County*, 497 F. Supp. 2d 403 (E.D.N.Y. 2007). The Chamber filed *amicus* briefs in the *Fielder* case before both the district court and the court of appeals.

The decision below conflicts with *Fielder* and *Suffolk County* and, therefore, threatens the uniform administration of ERISA plans. RILA and the Chamber filed *amicus* briefs in this case urging the Ninth Circuit to affirm the district court's decision holding the Ordinance preempted, and also in support of *en banc* rehearing.

SUMMARY OF ARGUMENT

I. Certiorari is warranted because the Ninth Circuit's decision directly conflicts with this Court's ERISA jurisprudence. Under this Court's test in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983), the San Francisco Ordinance has both an impermissible "reference to" and "connection with" employers' existing ERISA plans.

The Ordinance impermissibly "refer[s] to" ERISA plans under this Court's decision in *District of Co-*

lumbia v. Greater Washington Board of Trade, 506 U.S. 125 (1992), because its health-care spending options specifically include covered plans, and because it requires employers to measure compliance by referring to their current levels of ERISA benefits. The decision below cannot be reconciled with *Greater Washington Board of Trade*. In addition, the Ordinance "refer[s] to" an ERISA plan through the City-payment option, which is itself a covered plan under this Court's decision in *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987), and not, as the Ninth Circuit concluded, a non-ERISA alternative.

Contrary to the Ninth Circuit's holding, the Ordinance also has an impermissible "connection with" ERISA plans under this Court's precedents because, whether or not it offers non-ERISA means of compliance, it still interferes with uniform plan administration. In enacting ERISA, "Congress intended preemption to afford employers the advantages of a uniform set of administrative procedures governed by a single set of regulations." *Fort Halifax*, 482 U.S. at 11. State laws that threaten that goal of uniformity are therefore preempted, because "[r]equiring ERISA administrators to master the relevant laws of 50 states and to contend with litigation would undermine the congressional goal of minimizing the administrative and financial burdens on plan administrators—burdens ultimately borne by the beneficiaries." *Egelhoff v. Egelhoff*, 532 U.S. 141, 149-50 (2001) (internal quotation marks omitted).

The decision below conflicts with this Court's recognition of ERISA preemption's core purpose of uniform plan administration. By sustaining the Ordinance even though it mandates minimum health-care payments and recordkeeping requirements for employers who do business in San Francisco, the

Ninth Circuit's decision fosters the creation of a patchwork regulatory scheme for plan administrators and thereby creates the very burdens foreseen in, and forbidden by, *Fort Halifax* and *Egelhoff*. Certiorari should therefore be granted to correct the Ninth Circuit's erroneous departure from this Court's precedents.

II. Certiorari is also warranted to resolve the conflict between the Fourth and Ninth Circuits over whether ERISA preempts required-contribution laws like the Ordinance that require employers to make locale-specific per-employee expenditures on health care. In *Fielder*, the Fourth Circuit held that ERISA preempted a similar required-contribution law because the law's locale-specific minimum-spending and recordkeeping requirements "would hamper Wal-Mart's ability to administer its employee benefit plans in a uniform manner across the nation." 475 F.3d at 187. In particular, the Fourth Circuit recognized that a "proliferation of similar laws in other jurisdictions would force Wal-Mart or any employer like it to monitor these varying laws and manipulate its healthcare spending to comply with them." *Id.* at 197.

Contrary to the Ninth Circuit's reasoning, *Fielder* cannot be distinguished on the ground that the Maryland law at issue there effectively left employers with no alternative to altering or amending existing ERISA plans. The Fourth Circuit squarely held that, whether or not there were non-ERISA alternatives to compliance, required-contribution laws are preempted because they act directly on ERISA plans by increasing the burdens on plan administrators who must monitor and coordinate all employee health-care costs.

III. Finally, certiorari is warranted because this case presents a recurring issue of substantial importance—whether ERISA preempts laws like the Ordinance that mandate employer-funded health care. Given the current economic constraints on state and local budgets, the temptation to transfer to employers the costs of providing health care to the uninsured is certain to continue. A multiplicity of such state and local laws, however, would eviscerate ERISA's guarantee of uniform plan administration. And the resulting increase in compliance, monitoring, and litigation costs would ultimately result in increased expense to beneficiaries as well.

ARGUMENT

I. CERTIORARI IS WARRANTED BECAUSE THE DECISION BELOW CONFLICTS WITH THIS COURT'S ERISA JURISPRUDENCE.

ERISA broadly preempts all laws that "relate to" a covered employee benefit plan. 29 U.S.C. § 1144(a). Under this Court's precedents, a state or local law "relate[s] to" a plan if it has a forbidden "connection with" or "reference to" a plan. *Shaw*, 463 U.S. at 97. A state or local requirement impermissibly "refers to" a plan if the law on its face concerns ERISA plans, or if the employer must consult its existing benefit plans to measure compliance. *Greater Wash. Bd. of Trade*, 506 U.S. at 130. To determine whether a law has a "connection with" a plan, this Court looks to "the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive, as well as to the nature of the effect of the state law on ERISA plans." *California Div. of Labor Standards Enforcement v. Dillingham Constr., N. A., Inc.*, 519 U.S. 316, 325 (1997) (internal quotation marks omitted).

A. The Decision Below Conflicts With This Court's Precedents Regarding "Reference To" ERISA Plans.

1. The Ninth Circuit's decision conflicts with longstanding and straightforward precedent from this Court concerning what constitutes a "reference to" an ERISA plan. Under the terms of the Ordinance, an employer's compliance is determined by reference to its "health-care expenditures," which expressly include: "payments by a covered employer to a third party for the purpose of providing health care services for covered employees," and "contributions by such employer on behalf of its covered employees to a health savings account." S.F. Admin. Code § 14.1(b)(7)(a), (c). Employers undoubtedly establish ERISA plans when they make payments to a third-party insurer or to health savings accounts.[2] Therefore, the Ordinance on its face refers to ERISA plans, and assesses compliance by reference to employers' expenditures through such plans. Accordingly, contrary to the Ninth Circuit's holding below, the Ordinance "specifically refers to welfare benefit plans regulated by ERISA and on that basis alone is preempted." *Greater Wash. Bd. Of Trade*, 506 U.S. at 130.

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[2] As the Department of Labor has noted, health savings accounts are ERISA plans unless "the establishment of the HSAs is completely voluntary on the part of the employees." *See* Employee Benefits Sec. Admin., U.S. Dep't of Labor, Field Assistance Bulletin 2004-1 (Apr. 7, 2004). In addition, an employee can only establish a health savings account if he or she is already enrolled in a "high-deductible health plan," which, if provided by an employer, is itself an ERISA plan. *Id.*; *see also* 26 U.S.C. § 223(c)(1).

In *Greater Washington Board of Trade*, a District of Columbia law required employers to provide health benefits "equivalent to the existing health insurance coverage of [an] employee" while the employee was injured and on workers' compensation. *Id.* at 128 (internal citation omitted). The law was preempted because it referred to ERISA plans on its face, as demonstrated by the fact that employers measured compliance by reference to the benefit levels provided under their existing plans. *See id.* The Ordinance is preempted for the same reason: It refers to ERISA plans, and employers determine their legal obligations by consulting their expenditures made through those plans. If those plan expenditures are (in San Francisco's judgment) insufficient, payments to the City are compulsory. The decision below and *Greater Washington Board of Trade* are in direct conflict.[3]

The Ninth Circuit concluded that *Greater Washington Board of Trade* was inapplicable because the D.C. law at issue there measured compliance by referring to health-care *benefits*, whereas the Ordinance measures compliance by referring to health-care *payments*. Pet. App. 34a-35a. That purported

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[3] "Reference to" preemption results, as well, from the central role that benefit plans would play in the City's enforcement of the Ordinance. Most employers offer health care through ERISA-regulated plans. Enforcement of the Ordinance therefore will involve the City in examining employers' health plans, and—when non-compliance is alleged—in charging that employer contributions to the plans are insufficient to discharge obligations under the Ordinance. *Cf. Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 140 (1990) (when a plaintiff must "plead" an ERISA plan as part of a cause of action, the action "relate[s] to" the plan, "[b]ecause the court's inquiry must be directed to the plan").

distinction, however, has no basis in this Court's precedents and collapses under scrutiny. A health-care "benefit" to an employee is a health-care "payment" by the employer, either to a private health insurer or directly to the provider or employee. There can be no health-care "benefit" without a corresponding employer "payment."

Indeed, this Court summarily affirmed a decision rejecting this very distinction, holding that "laws that create funding requirements for employee benefit plans" are laws that "relate to" a plan, and "[s]tatutes regulating contributions to ERISA plans have consistently been held preempted." *Local Union 598, Plumbers & Pipefitters Indus. Journeymen & Apprentices Training Fund v. J.A. Jones Constr. Co.*, 846 F.2d 1213, 1218 (9th Cir. 1988), *summarily aff'd*, 488 U.S. 881 (1988); *see also id.*, 846 F.2d at 1219 ("this 'contribution/benefit' dichotomy, while perhaps superficially appealing, is unsupported by the law"). The judgment below cannot be reconciled with this Court's summary affirmance in *Local Union 598*. Upholding the Ninth Circuit's spurious distinction between benefits and payments would permit states to avoid ERISA preemption by elevating form over function, which this Court has expressly forbidden. *See Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981) ("ERISA's authors clearly meant to preclude the States from avoiding through form the substance of the pre-emption provision.").

Moreover, the Ninth Circuit's holding that statutes mandating employer "payments," rather than "benefits," are not preempted, conflicts with this Court's definition of an ERISA plan in *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987), and with the text of ERISA itself. ERISA defines an employee welfare benefit plan, in relevant part, as

> any plan, fund, or program . . . established or maintained by an employer . . . for the purpose of providing for its participants or their beneficiaries, through the *purchase of insurance or otherwise* . . . benefits in the event of sickness.

29 U.S.C. § 1002(1) (emphasis added).

In *Fort Halifax*, this Court made clear that, under the statute, an employer establishes or maintains an ERISA plan whenever the employer "assumes . . . responsibility *to pay benefits* on a regular basis," and "faces . . . periodic demands on its assets that create a need for financial coordination and control." 482 U.S. at 12 (emphasis added). In short, the obligation to make regular, periodic payments for employee benefits, plus the duty to monitor those payments, are the quintessential hallmarks of an ERISA-covered plan. *See id.* Therefore, the Ninth Circuit's insistence that a statute must expressly mandate specific "benefits" to have an impermissible "reference to" an ERISA plan conflicts directly with this Court's holding in *Fort Halifax*.

2. The Ninth Circuit's decision also conflicts with *Fort Halifax* in concluding that the Ordinance's creation of a City-run health benefits program, to the extent it is funded by private employers for the benefit of private employees, is not an ERISA plan. Pet. App. 15a. The City-payment option is a "plan" under *Fort Halifax* because it requires employers to make regular payments for employee benefits provided by the City, and to monitor, record, and disclose those payments. Because the City-payment option is an ERISA plan, the Ordinance impermissibly "refer[s] to" a covered plan for that reason as well.

To be sure, the requirement of a "one-time, lump-sum payment triggered by a single event," such as severance pay, neither "establishes, nor requires an employer to maintain," an ERISA plan because it "requires no administrative scheme whatsoever to meet the employer's obligations." *Fort Halifax*, 482 U.S. at 12. But the Ordinance requires employers to make regular quarterly payments to the HAP, not mere one-time, lump-sum payments. *See* S.F. Admin. Code § 14.3(a). In addition, in connection with these payments, an employer must determine each employee's eligibility for the HAP, apply exemptions for "managerial," "supervisory," and "confidential" employees, monitor the total hours that each employee works, calculate the total health-care expenditures required by the HAP for each employee, and maintain records establishing that the required payments were made each quarter. *See* Pet. App. 132a-133a; 143a-144a. That takes planning and an ongoing administrative scheme; it is done "for the purpose of providing for its participants or their beneficiaries . . . benefits in the event of sickness" (29 U.S.C. § 1002(1)); it is, therefore, a covered plan.[4]

In effect, the City has mandated that employers whose voluntary ERISA plans do not meet the City's standards must participate in an ERISA plan that does—namely, the City's plan. If the City had in-

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[4] This conclusion finds additional support in the Department of Labor's position as *amicus* before the Ninth Circuit that the City-payment option qualifies as a "plan." The Ninth Circuit erred by extending no deference to the Secretary's interpretation of ERISA. *See, e.g., Fed. Express Corp. v. Holowecki*, 128 S. Ct. 1147, 1156 (2008) (extending *Skidmore* deference to position taken by EEOC in policy memorandum issued after this Court granted certiorari).

stead required such employees to participate in a health insurance program provided by a specified private insurer, it would be perfectly clear that the City was mandating participation in an ERISA plan. The result does not change merely because the City itself (rather than a private insurer) operates the mandatory plan.

The court of appeals reasoned that the City-payment option is *not* an ERISA plan because it affords employers no more than a "modicum of discretion" over plan assets, and therefore presents little opportunity for employers to engage in mismanagement. Pet. App. 19a-20a. Nothing in the text of ERISA or in *Fort Halifax*, however, requires an employer to exercise a threshold level of discretion to operate an ERISA plan. On the contrary, employee welfare benefit plans (such as health-care plans) generally do not consist of an employer-managed trust fund and are exempt from ERISA's vesting, minimum-participation, and minimum-funding requirements. *See* 29 U.S.C. § 1051(1). But they are nevertheless covered plans.

It is true, of course, that an employer who elects the City-payment option is not responsible for the ultimate distribution of benefits once it makes payments to the City. This would also be true, however, under a private insurance agreement—once an employer paid the required premiums, the insurer would be responsible for administering the plan according to the terms of the policy. The only difference here is that the Ordinance requires employers to designate the City as the insurer of the plan—a difference that weighs in favor of, not against, a holding of preemption. *Cf. N.Y.S. Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 664 (1995) (suggesting that a law that "re-

quire[s] plans to deal with only one insurer, or to insure against an entire category of illnesses they might otherwise choose to leave without coverage," would violate ERISA); *Egelhoff*, 532 U.S. at 150 (state law dictating choice of beneficiary preempted by ERISA).

B. The Decision Below Conflicts With This Court's Precedents Regarding "Connection With" ERISA Plans.

The judgment below also conflicts with this Court's precedents holding that ERISA preempts state and local laws that have a "connection with" ERISA plans. The "connection with" inquiry centers on "the objectives of the ERISA statute" as well as "the nature of the effect of the state law on ERISA plans." *Dillingham*, 519 U.S. at 325. The test, therefore, is whether the law at issue interferes with ERISA's objectives. The court of appeals erroneously overlooked this Court's clear holding that among ERISA's principal objectives is "to provide a uniform regulatory regime over employee benefit plans." *Aetna Health*, 542 U.S. at 208.

Uniform plan administration serves multiple salutary purposes. First, it benefits the employer, or plan sponsor, by "minimiz[ing] the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government." *Ingersoll-Rand*, 498 U.S. at 142. Second, uniformity inures to the benefit of beneficiaries, as higher administrative costs can cause "employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them." *Fort Halifax*, 482 U.S. at 11. Third, elimination of inconsistent state regulation improves federal oversight of the "administrative integrity" of plan operations. *Id.* at 15.

The decision below ignores the reality that the Ordinance violates the objectives of uniform regulation set forth in *Aetna Health* and other precedents of this Court by mandating health-care benefit levels and imposing administrative requirements on San Francisco employers. Contrary to what the Ordinance presumes, employers do not ordinarily allocate health-care costs on a per-employee, per-location basis. Rather, employers generally provide company-wide coverage in order to reduce costs and diversify risk. The premiums that employers pay insurers are based on the overall profile of the insured group, and are not divided up to correspond to hours worked or the place of residence of each insured.[5] Alternatively, in the case of self-insurance, payments reflect the actual cost of health-care services—and again are not fixed according to how many hours an employee worked or where the employee lived.[6] Therefore, the Ordinance's threshold requirement that employers allocate health-care expenditures to specific employees in a specific location will, by itself, require employers to create a special pool of funds for San Francisco employees that is separate from the rest of the employees covered by the company plan. For this reason alone, the law is preempted.

Moreover, the efficiencies that result from a uniform plan—efficiencies that ERISA protects—are defeated when individual localities are permitted to re-

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[5] *See, e.g.*, *Fielder*, 475 F.3d at 194 (noting that "Wal-Mart does not presently allocate its contributions to ERISA plans or other healthcare spending by State, and so the [Maryland] Fair Share Act would require it to segregate a separate pool of expenditures for Maryland employees").

[6] *See, e.g.*, *Loren v. Blue Cross & Blue Shield*, 505 F.3d 598, 601 (6th Cir. 2007) (describing self-insured plans).

place actuarially-based calculations and market-determined pricing with government-imposed mandates. The need to monitor expenditures in multiple jurisdictions is squarely at odds with ERISA's purpose of establishing a uniform system of plan regulation. And as this Court has held, a crucial purpose of ERISA preemption is to prevent employers from having to deal with the difficulties inherent in complying with the idiosyncratic requirements of 50 states and countless municipalities.

In *Egelhoff*, this Court held preempted a Washington law that revoked a former spouse's status as a plan beneficiary following a divorce, even if the former spouse remained the named beneficiary on ERISA plan documents. *See* 532 U.S. at 144-45. Because this law "interfere[d] with nationally uniform plan administration," it had an impermissible "connection with" an ERISA plan. *Id.* at 148. In particular, if the law were upheld, multiple other jurisdictions might enact similar laws, each with its own peculiar rules for determining beneficiary status—even though ERISA specifically provides that the participant or the plan shall dictate the choice of beneficiary. *See id.* at 147-48. Therefore, this Court held that "[r]equiring ERISA administrators to master the relevant laws of 50 States and to contend with litigation would undermine the congressional goal of 'minimiz[ing] the administrative and financial burden[s]' on plan administrators—burdens ultimately borne by the beneficiaries." *Id.* at 149-50 (alterations in original and internal citation omitted).

The Ninth Circuit disregarded this Court's precedents in failing to acknowledge that the same holds true under the Ordinance. ERISA "does not create any substantive entitlement to employer-provided health benefits or any other kind of welfare

benefits," *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995); rather, it leaves the decision whether and when to provide benefits in the hands of employers and clears the way for uniform plan administration. The Ordinance, by contrast, disrupts plan uniformity by requiring employers to subsidize benefits (through health-care payments) in a particular locality that the employer would not otherwise provide. That is true whether the employer satisfies its obligations by purchasing additional benefits for employees through a private insurer, or by purchasing the bundle of benefits provided by San Francisco under the HAP. Under the decision below, employers would need to contend with a multiplicity of similar laws in other states and localities, each with their unique funding mandates and administrative requirements. *Egelhoff* forecloses and directly conflicts with this result.[7]

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[7] The Ninth Circuit nonetheless asserted that the Ordinance does not have a prohibited "connection with" an employer's ERISA plans because it merely influences *employer* conduct and has no effect on the *plan* itself. *See* Pet. App. 31a, 32a. This scholastic distinction—much like the benefit/payment dichotomy—makes no practical difference and is unsupported by precedent. Employers act as plan sponsors and administrators, and laws that mandate or proscribe an administrator's conduct necessarily have a direct effect on a plan. Indeed, this Court has made clear that Congress intended through ERISA "to ensure that plans *and plan sponsors* would be subject to a uniform body of benefits law[,]" and to eliminate "'the potential for conflict in substantive law . . . requiring the tailoring of plans *and employer conduct* to the peculiarities of the law of each jurisdiction.'" *Travelers*, 514 U.S. at 656-57 (quoting *Ingersoll-Rand*, 498 U.S. at 142) (emphasis added).

C. Under This Court's Precedents, Non-ERISA Alternatives Do Not Save A Law From Preemption.

Contrary to the Ninth Circuit's conclusion, the Ordinance is not saved from preemption merely because there are purportedly non-ERISA alternatives for complying with the law. Pet. App. 29a-30a. As an initial matter, as explained above, the City-payment option—the primary alternative offered by the Ordinance to modification of an existing plan—is *not* a non-ERISA alternative, but is instead an ERISA plan in its own right. Even leaving that point aside, the practical effect of the Ordinance and others like it on plan administration would still create the prohibited "connection with" an ERISA plan.

The Washington law in *Egelhoff*, for example, contained a provision that allowed employers to expressly "opt out" of the state-law rule by modifying their plan documents. 532 U.S. at 151. Nevertheless, this Court held that the existence of a statutory "opt out" did not save the law from preemption, because employers were still required to "maintain a familiarity with the laws of all 50 States so that they can update their plans as necessary to satisfy the opt-out requirements of other, similar statutes." *Id.* If the City-payment option were allowed to stand, employers would need to monitor the laws of all 50 states and make ongoing adjustments to ensure that their existing ERISA benefit levels complied with a myriad of state and local minimum-contribution requirements.

Similarly, in *Standard Oil Co. v. Agsalud*, 633 F.2d 760 (9th Cir. 1980), *summarily aff'd*, 454 U.S. 801 (1981), the State of Hawaii passed a law requiring employers to include a litany of specific benefits

in their health-care plans. The court of appeals held the law preempted by ERISA, and this Court summarily affirmed. In describing the decision, this Court explained in *Fort Halifax* that the Hawaii law was preempted because an employer's efforts to structure its existing plan to conform with the requirements of a single state would create the "difficulty or impossibility of structuring administrative practices according to a set of uniform guidelines." *Fort Halifax*, 482 U.S. at 13 (explaining *Agsalud*). In addition, "if Hawaii could demand the operation of a particular benefit plan, so could other States, which would require that the employer coordinate perhaps dozens of programs." *Id.* This interference with uniform plan administration is the very essence of a prohibited "connection with" an ERISA plan. Because the Ninth Circuit's decision conflicts with multiple decisions of this Court regarding what constitutes a "connection with" an ERISA plan, certiorari should be granted.

II. CERTIORARI IS WARRANTED BECAUSE THE DECISION BELOW CONFLICTS WITH THE DECISION OF THE FOURTH CIRCUIT IN *FIELDER*.

In *Fielder*, the Fourth Circuit correctly applied this Court's precedents in concluding that required-contribution laws have a prohibited "connection with" covered plans because they violate the core purpose of ERISA preemption: "establishing uniform, nationwide regulation of employee benefit plans." 475 F.3d at 191. By upholding the Ordinance, a local law that mandates particular levels of employee health care and a host of specific recordkeeping requirements, the Ninth Circuit created a direct conflict with *Fielder*.

A. The Ordinance Interferes With Uniform Plan Administration In The Same Manner As The Maryland Law.

In *Fielder*, the Fourth Circuit held that ERISA preempted the Maryland Fair Share Health Care Fund Act, which like the Ordinance required covered employers (namely, Wal-Mart) to make minimum health-care expenditures for employees or pay the difference to the government, and required covered employers to track expenditures with respect to those employees. *See* 475 F.3d at 183, 186-87.

The Ninth Circuit distinguished *Fielder* on the ground that the Maryland law did not provide employers with any genuine alternative to modifying their benefit plans. Pet. App. 38a-39a. The court of appeals reasoned that employers in Maryland received no benefit from electing to make payments to the State and therefore would be unlikely to choose that option, whereas employers who elect the City-payment option under the Ordinance can enroll eligible employees in the HAP, which provides employees with government-insured health care. *See id.*

The Fourth Circuit's judgment, however, was not dependent on the conclusion that Wal-Mart had no meaningful alternative to altering its ERISA plan. Rather, the court stated that even if there were "a meaningful avenue by which Wal-Mart could incur non-ERISA healthcare spending, we would still conclude that the Fair Share Act had an impermissible 'connection with' ERISA plans." *Fielder*, 475 F.3d at 196. As the Court explained, "[t]he undeniable fact is that the vast majority of any employer's healthcare spending occurs through ERISA plans . . . and any attempt to comply with the Act would have direct effects on the employer's ERISA plans." *Id.* Therefore,

> [i]f Wal-Mart were to attempt to utilize non-ERISA health spending options to satisfy the Fair Share Act, it would need to coordinate those spending efforts with its existing ERISA plans. . . . From the employer's perspective, the categories of ERISA and non-ERISA healthcare spending would not be isolated, unrelated costs. Decisions regarding one would affect the other and thereby violate ERISA's preemption provision.

Id. at 196-97.

In reaching this result, the Fourth Circuit relied on this Court's rejection in *Egelhoff* of Washington State's compelled-beneficiary law. As was true in *Egelhoff*, upholding the Fair Share Act would lead to other jurisdictions enacting similar required-contribution laws, which would "deny Wal-Mart the uniform nationwide administration of its healthcare plans by requiring it to keep an eye on conflicting state and local minimum spending requirements and adjust its healthcare spending accordingly." *Id.* at 197. And as in *Egelhoff*, the existence of an "opt out" provision did not save the Fair Share Act from preemption, because the law still "required plan administrators to 'maintain a familiarity with the laws of all 50 States so that they can update their plans as necessary to satisfy the opt-out requirements of other, similar statutes.'" *Fielder*, 475 F.3d at 197 (quoting *Egelhoff*, 532 U.S. at 151).

The Ordinance has the same impermissible consequences as the Maryland law. As in Maryland, the "undeniable fact" is that most San Francisco employers provide health care through ERISA plans. And as in Maryland, the undeniable effect of the Ordinance will be to increase the costs and burdens of

administering those plans—by requiring employers to: (1) coordinate their existing ERISA spending with additional spending to satisfy the minimum-contribution requirement; (2) maintain and disclose records regarding the spending required by the law; (3) monitor and comply with the laws of other jurisdictions; and (4) segregate and calculate the per-employee and per-location costs of providing health care. *See, e.g.*, *id.* at 194 (noting that Maryland law interfered with plan uniformity by forcing an employer to "segregate a separate pool of expenditures" for a specific location). Given the threat posed by required-contribution laws to uniform plan administration, and their resulting "connection with" ERISA plans, *Fielder* cannot be distinguished on the basis that the Ordinance provides for purportedly non-ERISA alternatives to compliance.

B. The Fourth Circuit's Holding Did Not Depend On An Absence Of Non-ERISA Alternatives.

To be sure, the Fourth Circuit in *Fielder* concluded that, under the Maryland law, no rational employer would choose to pay the State rather than alter or amend an existing ERISA plan. *See* 475 F.3d at 193. But this factual finding that the Maryland law was an effective mandate on employers was by no means necessary to the Fourth Circuit's analysis.

On the contrary, the "no rational employer" framework derives from a "trilogy" of Supreme Court decisions involving state laws that lay at the periphery of ERISA preemption because they either regulated third parties (rather than employers themselves) or otherwise had only an indirect economic

effect on ERISA plans.[8] When a law exerts only a "remote," "tenuous," or "indirect" economic influence on a plan—for example, by regulating insurers that do business with ERISA plans—it is not preempted unless the influence is so "prohibitive" that it effectively compels an employer to adopt a particular benefit or select a particular insurer. *Travelers*, 514 U.S. at 645, 661. As the Fourth Circuit recognized in *Fielder*, however, ERISA preemption of the Maryland law did not depend on any such "indirect" effect; rather, a law that mandates employer health-care contributions "*directly* regulates employers' structuring of their employee health benefit plans." *Fielder*, 475 F.3d at 195 (rejecting application of "trilogy" cases) (emphasis in original).

By concluding that the Ordinance survives preemption merely because it provides a supposed non-ERISA alternative, the Ninth Circuit converted one test for preemption—useful in cases of indirect regulation—into the sole criterion for whether a state or local law should be upheld. As the Court in *Fielder* recognized, however, no inquiry into the degree of economic coercion exerted by a state or local law is required when the law acts directly on employers and disrupts uniform plan administration. Rather,

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[8] *See Travelers*, 514 U.S. at 645 (statute requiring hospitals to collect surcharges from patients not insured by Blue Cross/Blue Shield was not preempted unless the surcharges were so "prohibitive" as to effectively require ERISA plans to provide insurance through the Blues); *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 809-10 (1997) (tax on hospitals and other health care providers for gross receipts of patient services not preempted by ERISA); *Dillingham*, 519 U.S. at 332-33 (no preemption of reduced minimum-wage incentive for employers to participate in a state-approved apprenticeship program).

required-contribution laws, by their very nature, dictate choices that ERISA leaves within the hands of employers and plan administrators. As a result, they interfere with uniform plan administration, have a forbidden "connection with" a plan, and therefore are preempted.

In short, the decision below cannot be reconciled with the Fourth Circuit's holding in *Fielder*. This Court should grant certiorari to resolve the conflict.

III. CERTIORARI IS WARRANTED TO RESOLVE AN IMPORTANT, RECURRING QUESTION OF FEDERAL LAW CONCERNING ERISA.

The Ninth Circuit's decision presents an important and recurring issue of federal law: whether ERISA preempts required-contribution laws like the Ordinance that require employers to make minimum health-care payments on behalf of employees. Because the Ninth Circuit's decision will frustrate uniform plan administration—the critical purpose underlying ERISA preemption—certiorari is warranted.

The threat of conflicting state and local regulations is not merely hypothetical. On the contrary, in addition to Maryland and San Francisco, other states and localities have already considered or adopted similar employer-contribution mandates. *See Fielder*, 475 F.3d at 184. For example, Suffolk County, New York, enacted an ordinance that required covered employers to pay health care costs of at least $3.00 per hour for each covered employee. *See Retail Indus. Leaders Ass'n v. Suffolk County*, 497 F. Supp. 2d 403, 406 (E.D.N.Y. 2007) (holding ordinance preempted by ERISA). As was true under the Ordinance, the Suffolk County ordinance required employers to track health-care expenditures for Suffolk County employers, record the dates and

hours worked of covered employees, and file annual reports with the county Department of Labor. *See id.*

Massachusetts and Vermont have also enacted similar required-contribution laws, each with their own specific minimum-payment and administrative requirements. *See, e.g.*, 114.5 MASS. CODE REGS. 16.03 (2009); VT. STAT. ANN. tit. 21, § 2003 (2009). In addition, similar proposals have been introduced in most other states. *See* J. Contreras & O. Lobel, *Wal-Martization and the Fair Share Health Care Acts*, 19 St. Thomas L. Rev. 105, 136 (2006) (collecting proposals).

Under the Ninth Circuit's reasoning, such state and local laws would be permitted to stand alongside the Ordinance, and employers would be forced to comply with differing minimum-payment and recordkeeping requirements in numerous states, cities, and counties across the Nation. Each additional jurisdiction that enacts such a law would force employers to segregate and track separate pools of expenditures for each jurisdiction and each covered employee. The resulting aggregate burden on plan uniformity, and the monitoring and compliance burdens on plan administrators, would be enormous. Therefore, this Court should grant certiorari to prevent the pernicious effect that the Ninth Circuit's decision will otherwise have on uniform plan administration.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted.

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GOLDEN GATE RESTAURANT ASSOCIATION,
Petitioner,

v.

CITY AND COUNTY OF SAN FRANCISCO,
Respondent,

SAN FRANCISCO CENTRAL LABOR COUNCIL, *et al.*,
Intervenors / Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF OF *AMICI CURIAE* SOCIETY FOR HUMAN RESOURCE MANAGEMENT, NATIONAL FEDERATION OF INDEPENDENT BUSINESS SMALL BUSINESS LEGAL CENTER, AND NATIONAL ASSOCIATION OF MANUFACTURERS IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI

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INTERESTS OF THE AMICI CURIAE

Amicus National Federation of Independent Business Small Business Legal Center ("NFIB Legal Center"), is a nonprofit, public interest law firm and is the legal arm of the National Federation of Independent Business ("NFIB"). NFIB is the nation's leading small business association, representing about 350,000 small businesses throughout the United States. *Amicus* Society for Human Resource Management ("SHRM") is the world's largest association devoted to human resource management, representing more than 250,000 individual members in over 140 countries and with more than 575 affiliated chapters in the United States. *Amicus* the National Association of Manufacturers ("NAM") is the nation's largest industrial trade association, representing small and large manufacturers in every industrial sector and in all 50 states.[1]

Two long-standing interests of the *Amici* are put in jeopardy by the decision of the Court of Appeals in this case: (1) preserving the exclusivity of federal

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[1] *Amici Curiae* NFIB Legal Center, SHRM, and NAM (collectively, "the *Amici*") have obtained the written consent of all the parties to file this brief with the Court. Pursuant to Supreme Court Rule 37.6, the *Amici* note that counsel for *Amici* wrote the entirety of this brief and that no person or entity, other than the *Amici*, their members, or their counsel, made a monetary contribution to the preparation or submission of this brief. The parties were notified more than ten days prior to the due date of this brief of the intention to file.

regulatory authority over employee benefit plans subject to Title I of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.* ("ERISA" or "the Act"), that this Court recognized over twenty-five years ago in *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 522 (1981); and (2) restoring the long-established judicial and regulatory consensus that any recurring process adopted by an employer to pay or provide in advance for health care coverage for its employees is an "employee welfare benefit plan" as defined in Section 3(1) of ERISA.

BRIEF OF *AMICI CURIAE* NATIONAL FEDERATION OF INDEPENDENT BUSINESS SMALL BUSINESS LEGAL CENTER, NATIONAL ASSOCIATION OF MANUFACTURERS, AND SOCIETY FOR HUMAN RESOURCE MANAGEMENT IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI

SUMMARY OF ARGUMENT

The petition for *certiorari* should be granted for three reasons.

First, the Ninth Circuit ruled that a private employer does not "establish[] or maintain[]" an employee welfare benefit plan within the meaning of those terms as used in Section 3(1) of ERISA when it makes regular, periodic payments in determinable amounts to pay for health coverage for its employees under programs established by a municipal ordinance. *See Golden Gate Restaurant Association v. City and County of San Francisco,* 546 F.3d 639, 646-47, 649-653 (9th Cir. 2008) ("*GGRA II*"). In reaching this conclusion, the Ninth Circuit departed from an essentially unanimous body of prior case law and regulatory guidance regarding what constitutes establishing or maintaining a plan. Thus, the decision in this case creates fundamental doubt over the applicability of Title I of ERISA as a whole, including its broad preemption provision, ERISA § 514(a).

Second, the Ninth Circuit's decision in this case is in direct conflict with the Fourth Circuit's decision in *Retail Industry Leaders Ass'n v. Fielder*, 475 F.3d 180, 196 (4th Cir., 2007) ("*RILA*"), regarding the application of ERISA § 514(a) to state and local "pay or play" laws. *See Golden Gate Restaurant Association v. City and County of San Francisco*, 558 F.3d 1000, 1006-07 (9th Cir. 2009) (M. Smith, Circuit Judge, dissenting from denial of petition for rehearing *en banc*) ("*GGRA III*"). The Court should grant the petition to resolve that conflict because its continuation will have immediate practical implications for employers that sponsor group health plans for their employees both within and outside the Ninth Circuit.

Third, the need to resolve the uncertainties created by the Ninth Circuit's decision in this case is especially urgent in light of the high priority the President and Congress have given to enacting comprehensive health care reform this year. Both the conflict between *GGRA II* and *RILA* over the application of ERISA § 514(a) and the more general uncertainty about what constitutes the establishment or maintenance of a welfare benefit plan are potential obstacles to adopting uniform federal health care reform legislation.

ARGUMENT

I. The Ninth Circuit held that ERISA does not preempt the health care spending requirement of the San Francisco Health Care Security Ordinance, as amended, San Francisco Administrative Code §§ 14.1 *et seq.* (2007) ("the Ordinance"). *GGRA II*, 546 F.3d

at 642. The Court of Appeals concluded that the spending mandate does not require a covered employer to adopt or amend an ERISA-governed plan. *Id.*, 546 F.3d at 646. The court reasoned that the "City-payment option . . . allows employers to make payments directly to the City . . . without requiring them to establish, or to alter existing, ERISA plans." *Id.* In support of this conclusion, the Ninth Circuit held that "An employer electing the City-payment option does not 'establish[] or maintain[]' the HAP [the City-administered plan] through its payments." *Id.*, 546 F.3d at 653 (*citing and quoting* ERISA Section 3(1), 29 U.S.C. § 1002(1), defining "welfare benefit plan").

The Ninth Circuit was profoundly mistaken in holding that an employer's election of the "City-payment option" does not entail the employer's establishment or maintenance of an ERISA plan, as the leading academic authority on ERISA preemption has pointed out. *See* E.A. Zelinsky, "'*Golden Gate Restaurant Association' Employer Mandates and ERISA Preemption in the Ninth Circuit*," Cardozo Legal Studies Research Paper No. 219, 23-28 (2008), available at http://ssrn.com/abstract=1090122. More significantly, the Ninth Circuit's mistake in this regard is not the result of misapplying established law to unusual facts. It is the product of a complete departure from existing law and regulatory guidance.

A. San Francisco's Ordinance has two primary components: a quarterly employer health care spending requirement, and a City-administered health care program. *GGRA II*, 546 F.3d at 642-43.

The employer spending provisions of the Ordinance mandate that covered employers make "required health care expenditures to or on behalf of" each of their covered employees each calendar quarter. Ordinance § 14.3(a); *see also GGRA II*, 546 F.3d at 643. The City-administered health program ("HAP") consists of a point-of-service arrangement ("Healthy San Francisco") and a Medical Reimbursement Account Plan. *See* Regulations Implementing Healthy San Francisco and Medical Reimbursement Account Provisions of the San Francisco Health Care Security Ordinance ("Plan Regulations"), § 7(c).

Although distinct, the employer spending requirement and the health care program components of the Ordinance are not entirely independent of each other. A "health care expenditure" is defined generally as any payment by an employer to or for the benefit of its covered employees "for the purpose of providing healthcare services to [its] covered employees or reimbursing the cost of such services to its covered employees." Plan Reg. § 4.1(A). The Ordinance defines "health care expenditure" to include payments to the City on behalf of one or more of the employer's covered employees. Ordinance, § 14.1(b)(7)(e). A payment of this kind is used to subsidize the covered employee's participation in the point-of-service arrangement (if the employee is a City resident and meets other requirements for Healthy San Francisco eligibility) or to fund a medical reimbursement account for the covered employee who does not meet the Healthy San Francisco eligibility requirements. *GGRA II, supra,*, 546 F.3d at 645. A covered employer can satisfy its spending requirement in whole or in part

by making quarterly payments in the required amounts to the City on behalf of one or more of the employer's covered employees. *Id.* Thus, when an employer chooses the "City-payment option" as a mode of compliance with the Ordinance's spending requirement, the employer's choice necessarily entails providing its employees prospectively with health care coverage on a programmatic basis through regular periodic payments that are made to a third party (the City) and used exclusively to provide medical coverage to those employees. *GGRA II*, 546 F.3d at 649-650.

B. On these facts, the Ninth Circuit concluded that "An employer electing the City-payment option does not 'establish[] or maintain[]' the HAP through its payments." *GGRA II*, 546 F.3d 653. The Court of Appeals cited no authority to support this conclusion, which is completely at odds with the statutory language, long-standing regulatory guidance, and a substantial body of case law.

Section 3(1) defines the term "employee welfare benefit plan" to include

> *any* plan, fund, or program . . . established or maintained by an employer . . . to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance *or otherwise* . . . medical, surgical, or hospital care or benefits . . . .

It has long been recognized that the degree of employer involvement necessary to trigger the application of this definition is minimal. As the Ninth Circuit itself observed more than two decades ago, "An employer . . . can establish an ERISA plan rather easily." *Credit Managers Ass'n v. Kennesaw Life & Accident Ins. Co.*, 809 F.2d 617, 625 (9th Cir. 1987). The statutory requirement that a plan be "established or maintained" by an employer has been interpreted merely to require that plan coverage is "part of an employment relationship." *Peckham v. Gem State Mut.*, 964 F.2d 1043, 1049 (10th Cir. 1992). *See also, Kenney v. Roland Parson Contracting Corp.*, 28 F.3d 1254, 1259 (D.C. Cir. 1994). Here, the Ordinance itself provides the necessary assurance that an employer choosing the City-payment option does so to fulfill an obligation to a covered employee in his or her capacity as such. Ordinance § 14.3(a).

Furthermore, an employer's election of the City-payment option is a deliberate choice to pay a third party to provide medical coverage for its employees. *GGRA III*, 558 F.3d at 1002. That fact alone is a sufficient basis on which to find that the employer "established" a plan subject to ERISA. *See, e.g., Madonia v. Blue Cross & Blue Shield of Virginia*, 11 F.3d 444 (4th Cir. 1993). Indeed, every Court of Appeals that seems to have considered the question has determined that the employer's payment of policy premiums or plan contributions for its employees' health coverage is "evidence" or "substantial evidence" that the employer established or maintained a welfare benefit plan. *Gruber v. Hubbard*, 159 F.3d 780, 789 (3d Cir. 1998); *Robinson*

v. Linomaz, 58 F.3d 365, 368 (8th Cir. 1995); *Madonia, supra*, 11 F.3d at 447; *Randol v. Mid-West Nat'l Life Ins. Co.*, 987 F.2d 1547, 1551 (11th Cir. 1993); *Brundage-Peterson v. Compcare Health Services Ins. Co.*, 877 F.2d 509, 511 (7th Cir. 1989); *Credit Managers Ass'n v. Kennesaw Life & Accident Ins. Co., supra*, 809 F.2d at 625; *Sipma v. Massachusetts Casualty Ins. Co.*, 256 F.3d 1006, 1012 (10th Cir. 2001) (substantial evidence of establishment); *see also, Postma v. Paul Revere Life Ins.*, 223 F.3d 533, 537 (7th Cir. 2000) ("An employer establishes or maintains a plan if it enters a contract with the insurer and pays its employees' premiums.") (citation omitted); *and cf. Kidder v. H & B Marine, Inc.*, 932 F.2d 347, 353 (5th Cir. 1991); *Grimo v. Blue Cross/Blue Shield of Vermont*, 34 F.3d 148, 151-52 (2d Cir. 1994), *and Wickman v. Northwestern National Insurance Co.*, 908 F.2d 1077, 1083 (1st Cir. 1990), *each citing and quoting Donovan v. Dillingham,* 688 F.2d 1367, 1373 (11th Cir. 1982) (*en banc*) ("the purchase of a group policy or multiple policies covering a class of employees offers substantial evidence that a plan, fund, or program has been established"). Thus an employer's implementation of a decision to make payments under the "City-payment option" clearly falls within the literal terms of the statutory definition of a welfare benefit plan, as reflected in the consensus of the Courts of Appeals.[2]

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[2] It is immaterial that the third-party recipient of the premiums in this case was created by municipal law and is open to numerous employers. "If an employer adopts for its employees a program of benefits sponsored by a group or association that does not itself constitute an 'employer' or an 'employee organization,' such an employer or employee organization may

C. Thus the question Petitioner seeks to present does not arise from a debatable application of settled law. It results from subverting and supplanting established law. This conclusion is evident from two of the bases on which the decision suggests that the City-payment option does not result in the establishment or maintenance of an employee benefit plan as a matter of law.

1. The Ninth Circuit concluded that if an employer's regular periodic payments of cash in an amount calculated based on the number of hours worked by the employee does not constitute an employee benefit plan under *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 16, (1987), and *Massachusetts v. Morash*, 490 U.S. 107, 109 (1989), then *a fortiori* the regular periodic payment under the Ordinance of the same amount, calculated on the same basis, to the City for the employee's benefit rather than to the employee directly does not constitute an employee benefit plan. *GGRA II*, 546 F.3d at 649-50.

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have established a separate, single-employer (or single employee organization) employee benefit plan covered by Title I of ERISA." ERISA Opn. Ltr. 96-25 (Oct. 31, 1996). *See also Patelco Credit Union v. Sahni*, 262 F.3d 897, 907-08 (9th Cir. 2001) ("[W]hether a multi-employer welfare arrangement itself is an employee welfare benefit plan is a separate question from whether an employer subscribing to a multi-employer welfare arrangement has established an ERISA employee welfare benefit plan vis-a-vis its own employees.")

This conclusion is quite literally the opposite of the conclusions reached by the Department of Labor in a body of regulatory guidance stretching back nearly thirty-five years. According to that guidance, an employer's payment to a third party for the benefit of its employee *causes* certain otherwise non-covered arrangements to be subject to ERISA. *See, e.g.*, ERISA Opn. Ltr. 77-90 (April 25, 1977) ("[a] vacation benefit account established pursuant to a collective bargaining agreement" under which "[e]ach contributing employer makes a payment to [an employers' association] based upon the number of hours credited to that employer's employees covered by the agreement" does not fall within the exemption under 29 C.F.R. § 2510.3-1(b)(3)(i) because the employer's association "deposits these contributions in the vacation benefit account and, pursuant to the agreement, distributes the vacation pay to the covered employees," and therefore payment is not made from an employer's general assets.); *and* ERISA Opn. Ltr. 94-14 (April 20, 1994) (payments of apprenticeship program benefits from a trust covered by ERISA, even though payments to the trust are "derived exclusively from employer contributions," in part because the benefits "are not paid from the general assets of an employer or an employee organization, as described in subsections 2510.3-1(b)(3)(iv) and 2510.3-1(k)."). *Cf.*, 29 C.F.R. § 2510.3-1(b)(3)(i) (exempting from coverage under ERISA payment of an employee's compensation during a vacation or holiday, if made from an employer's general assets); 29 C.F.R. § 2510.3-1(b)(3)(iv) (exempting from coverage under ERISA "[p]ayment of compensation on account of periods of time during which an employee performs little or no productive

work while engaged in training," but only if payment is made from the Employer's general assets); and § 2510.3-1(k) (exempting from ERISA coverage unfunded scholarship programs, *i.e.*, "scholarship program[s], including a tuition and education expense refund program[s], under which payments are made solely from the general assets of an employer or employee organization.") (August 15, 1975).

2. The second indication that the Ninth Circuit broke with established case law is that it declined to apply the well-recognized test for plan establishment first articulated by the Eleventh Circuit in *Dillingham, supra*, 688 F.2d at 1371 (11th Cir. 1982)[3] although it had followed *Dillingham* and adopted that test in the past.

The Ninth Circuit's refusal to apply the *Dillingham* test in this case is a conspicuous departure from precedent. *Dillingham* has been followed on point by every federal Court of Appeals with appellate jurisdiction over ERISA actions, including the Ninth Circuit itself. See *Wickman v. Northwestern National Ins. Co.*, 908 F.2d 1077, 1082-83 (1st Cir. 1990); *Guilbert v. Gardner*, 480 F.3d 140, 146 (2d Cir. 2007); *Deibler v. United Food &*

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[3] Under that test,

> a 'plan, fund, or program' under ERISA is established if from the surrounding circumstances a reasonable person can ascertain [1] the intended benefits, [2] a class of beneficiaries, [3] the source of financing, and [4] procedures for receiving benefits.

Id., 688 F.2d at 1373.

Commercial Workers' Local Union 23, 973 F.2d 206, 209 (3d Cir. 1992); *Elmore v. Cone Mills Corp.*, 23 F.3d 855, 861-862 (4th Cir. 1994) (*en banc*); *Memorial Hospital System v. Northbrook Life Ins. Co.*, 904 F.2d 236, 240-41 (5th Cir. 1990); *Brown v. Ampco-Pittsburgh Corp.*, 876 F.2d 546, 551 (6th Cir. 1989); *Ed Miniat, Inc. v. Globe Life Ins. Group, Inc.*, 805 F.2d 732, 738-39 (7th Cir. 1986); *Harris v. Arkansas Book Co.*, 794 F.2d 358, 360 (8th Cir. 1986); *Scott v. Gulf Oil Corp.*, 754 F.2d 1499, 1503-04 (9th Cir. 1985); *Peckham v. Gem State Mut.*, 964 F.2d 1043, 1047-48 (10th Cir. 1992); *Kenney v. Roland Parson Contracting Corp.*, 28 F.3d 1254, 1257 (D.C. Cir. 1994). The Ninth Circuit's refusal to apply the *Dillingham* test in this case is particularly ironic given that in 1985, the Ninth Circuit became the first Court of Appeals to follow that path, *see Scott, supra*, 754 F.2d at 1503-04, and had affirmed the continued vitality of *Scott* as recently as 2003. *See Winterrowd v. Am. Gen. Annuity Ins. Co.*, 321 F.3d 933, 939 (9th Cir. 2003).

3. The revolutionary character of the law applied below is also evident from the Ninth Circuit's ostensible basis for declining to apply *Dillingham*, as it had in the past. That departure from recently re-affirmed precedent was based on nothing more than the panel's "doubt" that the *Dillingham* test should be applied "to an employer's administrative obligations imposed by a state or local law." GGRA II, at 652.[4] However, any doubt on that score had

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[4] The *GGRA II* panel also stated that it "share[d] the view expressed by the Seventh Circuit in *Sandstrom v. Cultor Food Science, Inc.*, 214 F.3d 795 (7th Cir. 2000)," where *in dictum* the Seventh Circuit stated that, "It is not clear that the approach

nothing to do with the precise question to be considered, which was whether the *Dillingham* test should be applied to an employer's choice of method for discharging its "administrative obligations imposed by a state or local law," not to the obligations themselves. *GGRA II*, at 652.

Furthermore, the statutory text demonstrates that there is no basis for doubt that the definition of an employee welfare benefit plan under ERISA § 3(1) encompasses plans established or maintained merely by employer contributions to provide medical benefits in compliance with state law. ERISA § 4(b)(3) provides that, subject to a handful of statutory exceptions, Title I of ERISA applies generally to all employee welfare benefit plans and employee pension benefits as defined in Sections 3(1) and 3(2) of the Act. One of those exceptions is that Title I does not apply to "any employee benefit plan . . . maintained solely for the purpose of complying with applicable workmen's compensation laws." 29 U.S.C. § 1003(b)(3). This exemption is unnecessary (and its continuous presence in the text of the statute ever since the Act was adopted in 1974 is inexplicable) if an employer's systematic payments to a state workers' compensation fund, undertaken solely for the purpose of complying with applicable

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taken in *Dillingham* is compatible with more recent decisions of the Supreme Court, which emphasize different considerations when asking whether an informal policy or arrangement is a 'plan.'" *Id. at 797* (citations omitted). Since there is nothing "informal" about the terms of the City-payment option, it is difficult to see what is the significance for this case of the doubt expressed in the *Sandstrom* dictum.

workmen's compensation laws, cannot be an employee benefit plan to begin with.

D. *GGRA II*s departure from a long-standing and virtually unanimous body of prior case law and regulatory authority is tremendously significant. The question whether a plan, fund, or program is "established or maintained" is implicated in literally every case where Title I of ERISA provides a basis for subject matter jurisdiction and/or a rule of decision. *See, e.g., Int'l. Association of Entrepreneurs v. Foster*, 883 F. Supp. 1050, 1056 (E.D.Va. 1995) & n.2 (federal court must determine whether plaintiff's plan is covered by ERISA, even if that fact is not outcome-determinative, because subject matter jurisdiction depends on it). The establishment or maintenance of a plan, fund, or program of some kind by an employer or employee organization is a prerequisite for finding that an employee benefit plan exists. *See* ERISA § 3(3) (defining "employee benefit plan" or "plan" to mean an employee welfare benefit plan or an employee pension benefit plan) *and see also* § 3(1) (defining "employee welfare benefit plan") and § 3(2) (defining "employee pension benefit plan"). The existence of an employee benefit plan is a prerequisite for the application of any provision of Title I of ERISA, including the jurisdictional provisions of Section 502, 29 U.S.C. § 1132. *See* ERISA § 4(a). Moreover, fundamental rights and guarantees such as the right to elect post-employment continuation coverage under an employer-sponsored group health plan (popularly referred to as "COBRA") depends on the establishment or maintenance of a plan. *See, gen'ly*, ERISA §§ 601 *et seq., and esp.* § 607(1) (defining

"group health plan" as a subset of employee welfare benefit plans).

II. Even if the Ninth Circuit were correct that an employer's election of the City-payment option is not the establishment or maintenance of an employee benefit plan, the *GGRA* decision directly conflicts with the Fourth Circuit's decision in *RILA* regarding the application of this Court's ERISA Section 514 jurisprudence. The very existence of that conflict creates uncertainties about the design of employee benefit plans that impinges on the ability of multi-jurisdictional employers to continue to provide employee health coverage and other benefits as they have done in the past. Given the huge percentage of Americans for whom the only source of health coverage is an employer-sponsored plan, the continuation of this uncertainty threatens a crucial component of the existing health care delivery system in the United States.

A. Despite minor variations in the surrounding facts, both *RILA* and *GGRA* rule on the same question: is a state or municipal employer health care spending mandate saved from preemption by ERISA as a matter of law merely because it includes a provision that the state or municipality characterizes as allowing an employer to comply with the spending requirement by a means other than an ERISA-governed plan?

In *RILA*, the Fourth Circuit held that ERISA § 514(a) preempted Maryland's Fair Share Health Care Fund Act, 2006 Md. Laws 1, *Md. Code Ann., Lab. & Empl.* §§ 8.5-101 to 107 (2006) ("the

Maryland Fair Share Act"), on two bases. The Maryland Fair Share Act imposed a spending requirement on a covered employer by requiring the employer to calculate the amount by which its health care expenditures for its Maryland employees fell short of 8% of its Maryland payroll, and to pay an amount equal to the shortfall to the state. Under the Maryland Fair Share Act, payments received by the state could be spent only on the Maryland Medical Assistance Program, which consisted of Maryland's Medicaid and children's health programs. 475 F.3d at 185, *citing* Md. Code Ann., Health-Gen. § 15-142(f). As Respondents are expected to do here, Maryland characterized the statute at issue in *RILA* as offering a compliance option (payments to the state) that did not require a covered employer to establish or maintain an ERISA-governed plan. 475 F.3d at 190, 194-95.

The first basis on which the Fourth Circuit held the Maryland Fair Share Act preempted by ERISA was that the Act did not offer a genuine non-ERISA alternative to complying with the minimum spending mandate, and therefore "effectively requires [covered] employers in Maryland . . . to restructure their employee health insurance plans." 475 F.3d at 183. Respondents likely will argue that *GGRA* does not conflict with *RILA* because in *GGRA*, the Ninth Circuit believed the Ordinance offered a genuine non-ERISA compliance option.

However, *GGRA* and *RILA* are in direct and irreconcilable conflict regarding the alternative basis on which the Fourth Circuit held that the Maryland Fair Share Act was preempted by ERISA. As

explained by Circuit Judge Smith in his dissent from the Ninth Circuit's denial of *en banc* review,

> The *Fielder* court explained that even were there a more "meaningful avenue" by which the employer could make non-ERISA healthcare payments, the Maryland statute was still impermissibly connected to ERISA plans. 475 F.3d at 196-97 ("If [the employer] were to attempt to utilize non-ERISA health spending options to [comply with the statute], it would need to coordinate those spending efforts with its existing ERISA plans. . . . Decisions regarding one would affect the other and thereby violate ERISA's preemption provision."). Covered employers under San Francisco's Ordinance must coordinate their non-ERISA payments with their ERISA plans in the very manner the *Fielder* court deemed impermissible. *GGRA III*, 558 F.3d at 1006-07.

B. The importance of resolving this conflict is clear because it stems directly from employers' reliance on the well-established principle that state law cannot dictate benefit plan design. In *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96, 97 (1983), this Court established that for purposes of Section 514(a), a state law "relates to" an employee benefit plan "if it has a connection with or reference to such a plan." *Id.* (footnote omitted). It is generally understood that under the "connection with" branch of *Shaw*, state law cannot require that an employer design a new or existing welfare benefit plan to coordinate its functions with a state law, even if the state law does not refer to the ERISA-governed plan.

Not unexpectedly, then, the conflict between *RILA* and *GGRA II* regarding "connection with" preemption under *Shaw* poses numerous practical difficulties for any business with locations in San Francisco and locations elsewhere. For example, it has been reported that such employers face difficult payroll tax and wage reporting issues that stem from having one or more self-insured health plans for employees not covered by the Ordinance and a different arrangement to comply with the Ordinance for covered employees. *Pension and Benefits Reporter*, Vol. 36, No. 20 (BNA) (May 19, 2009) (noting that such a scenario might fail to satisfy certain nondiscrimination provisions essential to favorable tax treatment of employer-provided coverage under Section 105 of the Internal Revenue Code). It is therefore essential that all parties responsible for adopting, amending, and administering those plans know as soon as possible whether and to what extent state and local law may apply either instead of or in addition to ERISA, so that they may plan accordingly.

Resolving the conflict is important at a more fundamental level, as well. ERISA's broad preemption provision was a key element by which Congress established "[a] zone of employer autonomy in the design and operation of employers' welfare plans." *See* E.A. Zelinsky, *Maryland's "Wal-Mart" Act: Policy and Preemption*, 28 Cardozo L.Rev. 847, 869 (2006). *Cf. Inter-Modal Rail Employees Ass'n. v. Atchison, Topeka & Santa Fe Ry. Co.*, 520 U.S. 510, 515 (1997) (ERISA's grant of employer's freedom to amend plans prospectively encourages employer to

adopt more generous benefits at the outset). Yet, as the District Court correctly found, the Ordinance "interfere[s] with preserving employer autonomy over whether and how to provide employee health coverage." *Golden Gate Restaurant Association v. City of San Francisco*, 535 F. Supp.2d 968, 975 (N.D. Cal. 2007). Thus, the conflicting approaches in *GGRA II* and *RILA* to the "connection with" branch of this Court's ERISA Section 514(a) preemption case law creates an obstacle to the continuation and growth of employer-sponsored group health plans, particularly where the employer has employees both within and outside the Ninth Circuit.

Removing this obstacle is an urgent matter because employment-based coverage is the predominant method for providing health coverage in the United States. Almost 133 million Americans currently obtain health coverage through plans maintained by employers in the private sector. *See* Statement of John J. Castellani, President, Business Roundtable, speaking before the Senate Finance Committee during a roundtable discussion on healthcare coverage on May 5, 2009, available at http://finance.senate.gov/sitepages/hearing050509.html. Sixty-two percent of Americans under age 65 receive health benefits through their employers or a family member's employer. *See, HRET/Kaiser Family Foundation, 2008 Employer Health Benefits Survey*, http://ehbs.kff.org/pdf/7790.pdf.

III. The uncertainty engendered by the decision in this case is especially problematic because of when it arose—*i.e.*, on the eve of a national consensus that the federal government must devise a comprehensive

solution to the widespread lack of affordable health coverage. *See* Roundtable to Discuss Reforming America's Health Care Delivery System: Hearing Before S. Committee on Finance, 111th Cong. (April 21, 2009), available at http://finance.senate.gov/sitepages/hearing042109.htm; and Roundtable Discussion on "Expanding Health Care Coverage": Hearing Before S. Committee on Finance, 111th Cong. (May 12, 2009), available at http://finance.senate.gov/sitepages/hearing050509.html. Unless that uncertainty is resolved by this Court, it will impede Congress's ability to arrive at a workable solution.

A. Employer-provided health coverage is so entrenched as part of our current system that any reform of health care coverage in the United States inevitably will involve employer-sponsored group health plans covered by Title I of ERISA, at least as a transitional measure. This conclusion is evident from both of the reform measures adopted by the 111th Congress to date, each of which uses ERISA-governed group health plans as vehicles for providing coverage to those who otherwise might be uninsured.

The Children's Health Insurance Program Reauthorization Act of 2009, Pub. Law 111-3 (Feb. 4, 2009) ("CHIPRA"), authorizes states to offer federally funded premium subsidies to defray the cost of covering targeted low-income children under certain group health plans maintained by their parents' employers. *See* 42 USC § 1397ee(c)(10)(A), as added by Pub. Law 111-3, Tit. III, Subtitle A, § 301(a)(1) (Feb. 4, 2009). CHIPRA also amended Section 701(f) of ERISA to require employer-

sponsored group health plans to provide special enrollment rights based on changes in eligibility for the premium subsidies, and to require employers to give employees written notice of the potential opportunity for premium subsidies in the states in which the employees reside. Pub. Law 111-3, Tit. III, Subtitle B, § 311(b)(1)(A).[5]

The American Recovery and Reinvestment Act of 2009, Pub. L. 111-5 (Feb. 17, 2009) ("ARRA"), requires employer-sponsored group health plans, including those governed by ERISA, to treat "assistance eligible individuals" who pay 35% of a plan's monthly premium for continued post-employment coverage as if they had paid 100% of the required monthly premium under specified conditions. ARRA, Title III, § 3001(a)(1). Prior to the ARRA, federal law did not impose continuation coverage requirements on group health plans sponsored by relatively small employers, leaving the

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[5] CHIPRA also includes an affirmation of the Senate's intention to enact legislation in 2009 that "improves access to affordable and meaningful health insurance coverage for *employees of small businesses* and individuals by . . . facilitating pooling mechanisms, *including pooling across state lines*; and *providing assistance to small businesses* and individuals, including financial assistance and tax incentives, for the purchase of private insurance coverage." *Id.*, § 622(b)(3) (emphases added). The linkage between financial assistance to small businesses and improving the insurance opportunities of the employees of small business demonstrates a commitment to the continued use of ERISA-governed plans as instruments of coverage reforms. The commitment to pooling across state lines demonstrates that Congress continues to think, as it has since 1974, that state laws which could impede the continued vitality of employer-sponsored plans should be displaced by federal law.

matter entirely to state law. ERISA § 601(b), 29 USC § 1161(b). By contrast, the premium subsidy provisions of ARRA apply to employer-sponsored group health plans that are required by state law to provide post-employment continuation coverage.

Similarly, other federal initiatives currently under consideration also would act through employer-provided group health plans to change how health care is financed and provided in the United States. For example, the initial drafts of the "Affordable Health Choices Act" proposed by the Senate Health, Education, Labor and Pensions ("HELP") Committee in June 2009, would amend ERISA to prohibit pre-existing condition exclusions, abolish limits on annual or lifetime benefits, extend to 26 the age at which a dependent may be covered, limit which employers may adopt self-insured plans, and mandate employers cover employees or pay a penalty.

B. Continued uncertainty about the scope of state and municipal authority to mandate employer-sponsored health care expenditures is an impediment to reaching a resolution on national health care reform. If state and local governments may attach health care financing obligations to employment, the advocates of any federal initiative that will be implemented via employer-provided group health plans must decide whether and to what extent to propose that state and local mandates be taken into account in defining an employer's federal obligations. At the same time, if ERISA does preempt state and local measures such as the San Francisco HCSO, the advocates of allowing the states

to function as laboratories for the improvement of health care delivery and finance would be required to include a cut-back on the scope of ERISA preemption in measures they advocate.

At best, the uncertainty over what the law currently allows in the way of state and local mandates will waste valuable legislative time and energy on debate over whether and how to limit state and local authority, or whether and how to accommodate its unpredictable future exercise in federal legislation. At worst, the uncertainty could impede the compromises, splinter the coalitions, and prevent the formation of the consensus necessary to enact any meaningful health care reform. This is so because the decision in *GGRA II* completely unravels the legislative compromises reached at the national level in 1974 that allowed Congress to pass ERISA. *Cf.* Michael S. Gordon, *Introduction: The Social Policy Origins of ERISA*, in Employee Benefits Law (S.J. Sacher and J.I. Singer, eds., ABA, 2d ed. 2000) at xc–cii (ERISA would not have been adopted if it had not been premised on preserving employer autonomy over plan adoption and plan design).

Thus *GGRA* II leaves Congress with an unpalatable choice if it wants to harness employer-provided group health plans successfully as an engine of national health care reform: it either must revisit the controversies surrounding ERISA preemption that it resolved thirty-five years ago while simultaneously trying to reconcile all of the contemporary issues that have made reform legislatively unobtainable until now, or it must abandon any hope of a nationally uniform solution to

what a national constituency clearly believes is a national crisis. Moreover, the conflict between the Ninth and the Fourth Circuits will act as an impediment to fashioning a successful bill regardless of whether it favors state employer mandates or leaves no room for them. Proponents of either position will be forced to guess which of the *GGRA II* or the *RILA* decisions represents the true state of the law in order to know whether their bills must contain a provision augmenting or reducing the scope of federal preemption under ERISA.

As the leading historian of ERISA has noted, giving ERISA broad preemptive effect was essential to its adoption. "The desire for federal preemption was a key factor – perhaps, the key factor – in creating the coalition that pushed ERISA through Congress." J.A. Wooten, *A Legislative and Political History of ERISA Preemption, Part I*, 14 J. of Pension Benefits 10 (2006). That compromise came only after a protracted, hard-fought battle that lasted many years. There is no reason to believe that the rematch forced on Congress by the decision in this case will be any less contentious than the original battle.

CONCLUSION

The petition should be granted.

Respectfully submitted,

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In the Supreme Court of the United States

GOLDEN GATE RESTAURANT ASSOCIATION,
PETITIONER

v.

CITY AND COUNTY OF SAN FRANCISCO, ET AL.
RESPONDENTS.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE WASHINGTON LEGAL FOUNDATION AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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QUESTION PRESENTED

Whether ERISA section 514(a), 29 U.S.C. § 1144(a), preempts local "pay-or-play" laws mandating that employers with ERISA-regulated benefit plans: (1) pay specified amounts to obtain health care benefits for employees employed within the locality, and (2) comply with detailed coverage and record-keeping requirements beyond those required by ERISA?

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INTRODUCTION AND INTEREST OF AMICUS CURIAE[1]

The decision below poses a serious threat to the viability of the voluntary employer-provided benefit systems relied upon by an estimated 177 million U.S. residents for, among other things, their health care needs. These plans are generally regulated by the federal Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001 *et seq.*, which encourages employers to provide health and welfare benefits through an efficient, uniform regulatory structure, backed by a preemption provision that this Court has aptly characterized as "conspicuous for its breadth." *FMC Corp.* v. *Holliday,* 498 U.S. 52, 58 (1990); *see* ERISA section 514(a), 29 U.S.C. § 1144(a).

Notwithstanding ERISA's broad preemption provision, in recent years numerous state and local governments have attempted to mandate benefits or benefit levels for employees at private companies through so-called "pay-or-play" laws. These laws generally require employers to spend specified amounts on health care on behalf of their employees, either by providing those benefits directly through their ERISA-governed plans ("play"), or by paying the state or local government to provide such benefits ("pay"). These attempts generally have failed, in

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[1] Pursuant to Supreme Court Rule 37.6, no counsel for a party authored this brief in whole or in part. No person or entity, other than the Washington Legal Foundation and its counsel, made a monetary contribution intended to fund the preparation and submission of this brief. WLF is filing its brief with the consent of all parties. Letters of consent have been lodged with the Court.

large part because legislators have believed, and courts (including the Fourth Circuit) have found, that such mandated benefit programs are preempted by ERISA.

In the decision below, however, the Ninth Circuit ruled that a typical "pay-or-play" scheme—this one imposed by the San Francisco Health Care Security Ordinance—is *not* preempted by ERISA. That decision will now permit the enactment of similar schemes throughout the Ninth Circuit–which covers some twenty percent of the U.S. population. And the decision, unless reversed, is likely to open the floodgates to massive waves of state and local regulation of ERISA-governed health plans in other circuits as well—regulation that will dramatically increase the cost and administrative burden associated with providing health care benefits. Such a patchwork quilt of regulation – which is precisely what Congress intended to prevent with the enactment of ERISA – will have far-reaching, adverse consequences for the cost of employer-sponsored health care benefits. It will also adversely affect the provision of retirement and other ERISA benefits, which many employers may scale back or eliminate as a result of the increased financial burdens created by "pay-or-play" schemes like the one at issue here.

Such a result would seriously disserve the interests of *amicus curiae,* the Washington Legal Foundation ("WLF"). WLF is a non-profit public interest law and policy center based in Washington, D.C., with supporters in all 50 states. WLF devotes a substantial portion of its resources to defending and promoting free enterprise, individual rights, and a limited, accountable government. WLF regularly appears in

this Court and other federal courts to express its view that government should avoid over-regulation of business. WLF further believes that "pay-or-play" laws like the one at issue here do just that.

STATEMENT

The San Francisco Health Care Security Ordinance (the "Ordinance"), S.F. Cal. Admin. Code, Ch. 14 (2008), has two key components: an employer health spending requirement, and the Health Access Program ("Program"), a city-run health care program funded in part by employer contributions. App. 84a–85a. The Ordinance requires employers to meet minimum health care spending levels for each covered employee—either by making direct payments to the City and County of San Francisco ("City") "to be used on behalf of covered employees" through the Program, or by paying for qualifying health care benefits through other means. *Id.* at 84a. The Ordinance imposes detailed reporting requirements for each covered employee. *Id.* at 85a. The Ordinance creates a new administrative regime to enforce compliance. *Id.* at 85a.

Golden Gate Restaurant Association ("GGRA"), a non-profit association that promotes the interests of the restaurant industry, filed suit in district court seeking an injunction against the enforcement of the Ordinance's employer health spending requirements. *Id.* at 85a–86a. The U.S. District Court for the Northern District of California granted summary judgment in favor of GGRA. *Id.* at 93a. The district court found the Ordinance had "an impermissible connection with employee welfare benefit plans," and therefore was preempted. The court concluded that the Ordinance, *inter alia,* interfered with the nation-

ally uniform administration of ERISA plans, and it imposed recordkeeping, inspection, and other administrative burdens related to employer health care expenditures that went well beyond ERISA's requirements. *Id.*, at 94a, 97a. The district court also found that ERISA preempted the employer spending requirements because they made "unlawful reference to employee benefit plans." *Id.* at 98a.

The Ninth Circuit reversed. It held that the Ordinance did not "relate to" ERISA plans because it did not *require* employers to establish or alter ERISA plans, *i.e.*, they could choose to make payments to the City and leave their plans intact. *Id.* at 11a–12a; 14a. The Ninth Circuit also held that the Ordinance did not make an unlawful "reference to" ERISA plans, in part because "an employer's obligations to the City are measured by reference to the *payments* provided by the employer" rather than the "*benefits* provided by the ERISA plan to the employee." *Id.* at 35a.

The Ninth Circuit denied GGRA's petition for rehearing *en banc* over a dissent by Judge Milan D. Smith, joined by seven judges. GGRA petitioned this Court for a Writ of Certiorari.

REASONS FOR GRANTING THE PETITION

The Petition raises an issue of exceptional importance: whether the administration of the employer-sponsored health care benefits of some 177 million persons can be made subject to separate regulation in potentially 50 states and 30,000 localities, with each state and locality being allowed to impose its own contribution and record-keeping requirements, and its own compliance and enforcement machinery. As the judges who dissented from the denial of the peti-

tion for *en banc* review pointed out, the panel's decision provides every state and local jurisdiction in the Ninth Circuit – and arguably in the entire nation – a "roadmap...on how to design and enact a labyrinth of laws requiring employer compliance on health care expenditures, thereby creating the very kind of health care balkanization ERISA was intended to avoid." Pet. App. 49a (M. Smith, J., *dissenting*).

If allowed to stand, the Ninth Circuit's decision will set off a chain reaction of state and local regulation that will undermine employer-sponsored benefit plans. Mandated contributions in some states and localities will create pressure on employers to alter their plans to make them less costly in states and localities without mandated contributions. That, in turn, will create pressure on states and localities to implement mandates to protect their own citizens. Each new law will create its own standards of coverage, contribution levels, record-keeping and reporting requirements, and enforcement mechanisms.

WLF agrees with the analysis presented in the Petition demonstrating (a) the existence of a circuit conflict on the question presented, and (b) the impossibility of reconciling the Ninth Circuit's decision with ERISA's preemption provision and this Court's decisions interpreting that provision. WLF writes separately to explain how the cumulative burden of state and local laws that will quickly be enacted will have potentially disastrous consequences for the administration of employee health care and other benefit plans, if the Court does not forestall such legislation by granting the petition and reversing the Ninth Circuit's decision. WLF addresses first, how the Ordinance burdens employers, second, how these bur-

dens will only increase as other state and local governments follow San Francisco's example, and finally, why "Pay-or-Play" laws are preempted under ERISA.

I. The San Francisco Ordinance Imposes Substantial Burdens On Employers In The Provision Of Employee Health Care Benefits.

To assess the burden that the Ordinance places on employers, and therefore, on the implementation and administration of employer-sponsored ERISA plans, it is important to understand the Ordinance's structure and administrative requirements. These requirements, which exist separate and apart from ERISA, are detailed below. And they impose enormous burdens on employers, especially small- and medium-sized employers.

A. Covered Employers Must Undergo A Detailed Analysis To Determine The Required Contribution Levels For Each Covered Employee.

For example, the Ordinance requires employers to undertake a detailed analysis to determine their obligation to make benefit contributions to the City on behalf of employees. The City summarizes the process in a four page, multi-step decision tree.[2]

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[2] San Francisco Office of Labor Standards Enforcement, Steps to Determine Whether a Covered Employer Has Met its Spending Requirement under the SF Health Care Security Ordinance (HSCO) 1 http://www.sfgov.org/site/uploadedfiles/olse/hcso/Steps%20to%20Calculate%20HCE%20flowchart(1).pdf (last visited Jul. 8, 2009).

First, an employer must determine whether it is a "covered employer," and if so, whether it is a "large" or "medium" employer. S.F. Admin. Code §§ 14.1(b)(3), (11), (12), (15).

Second, if the employer is "covered," it must ascertain which of its employees are "covered." S.F. Admin. Code § 14.1(b)(2). The definition does not include all San Francisco-based employees, but may include employees located elsewhere. To be covered, an employee must work in the City and be entitled to payment of a minimum wage pursuant to the San Francisco Minimum Wage Ordinance. §§ 14.1(b)(2), 12R. The employee must have been employed for ninety days (though not necessarily continuously or consecutively), and must have worked a number of hours in San Francisco that varies from year to year. §§ 14.1(b)(2)(a)-(c); Office of Labor Standards Enforcement ("OLSE" or "Enforcement Office") Regulations No. 3.1(B).

If these criteria are met as to *any* employee, the employer must then determine whether the employee falls within a number of exclusions from coverage. An otherwise covered employee is excluded if he or she: (1) is "managerial, supervisorial, or confidential, unless such employees earn annually under...[a] figure as set by the administering agency" S.F. Admin. Code § 14.1(b)(2)(d); (2) is eligible for Medicare or TRICARE/CHAMPUS, § 14.1(b)(2)(e); (3) is a "covered employee" as defined by San Francisco's (separate) Health Care Accountability Ordinance. S.F. Admin. Code §§ 14.1(b)(2)(f), 12Q; (4) is employed by a nonprofit corporation for up to one year as a trainee in a bona fide training program consistent with Federal law, which enables the trainee to advance into a

permanent position, provided that the trainee does not replace, displace, or lower the wage or benefits of any existing position or employee, S.F. Admin. Code § 14.1(b)(2)(g); or (5) has benefits through another employer and signs a voluntary written waiver of the Ordinance's requirements that is revocable by the employee at any time. § 14.1(b)(2)(h).

Third, employers must determine how much the Ordinance requires them to spend on health care benefits. To do so, they must determine the applicable hourly rate, which varies depending on the employer's size and the time-period covered. S.F. Admin. Code § 14.1(b)(8). Then, they must multiply the applicable hourly rate by the number of hours for which the employee was paid in the period for work "performed within the City." S.F. Admin. Code § 14(b)(10). Work is done "within the City" if the employee performs the work within the geographic boundaries of the City, including employees who work from their homes within the City limit, and employees whose work requires them to make stops (*e.g.*, for deliveries) in the City (but not who merely drive through the City). OLSE Reg. No. 3.1(C).

Fourth, the employer must determine how much of the money it spends on "health care benefits" can be used as an offset against the spending mandate during the period. Offsets include (but are not limited to): (a) contributions by an employer on behalf of the employee to a health savings account; (b) reimbursement to the employee for expenses incurred in the purchase of health care services; (c) payments to a third party for the purpose of providing health care services for the employee; and (d) costs incurred by the employer in the direct delivery of health care ser-

vices. S.F. Admin. Code § 14.1(b)(7). Expenditures made by self-insured and/or self-funded insurance programs also may be included, but payment of prevailing wage fringe benefit obligations in cash may not. OLSE Reg. No. 2(A)(2), (B)(1).

Finally, the employer must pay the difference between the spending requirement and the amount it spends in recognized health care expenditures for each covered employee. S.F. Admin. Code § 14.3(a).

It is apparent that undertaking this detailed, fact-specific analysis for *each* employee who may be covered under the Ordinance imposes substantial compliance requirements on employers.

B. Covered Employers Must Comply With Detailed Record-Keeping and Reporting Requirements Separate And Apart From Their Obligations Under ERISA.

In addition to the above compliance requirements, covered employers must maintain records "sufficient to establish compliance with Employer Spending Requirements of th[e] Ordinance." OLSE Reg. No. 7.2(A)(3). Employers thus must maintain detailed records that are not required by ERISA (or otherwise). Such documentation includes records of hours or work performed by each employee within the City (regardless of where he or she is regularly employed); records of the time counted toward the employee's initial 90 days of employment (which may be non-consecutive or non-continuous); records justifying an employee's classification as managerial, supervisory or confidential; records of whether the employee is eligible for Medicare or TRICARE/CHAMPUS; and records of the contributions that entitle the employer to an offset.

Where an employer undergoes a reduction in force that would reclassify it to an employer of smaller size, and hence reduce its contribution levels, it must also maintain documentation sufficient to prove that the reduction was not implemented for the purpose of evading its obligations under the Ordinance. S.F. Admin. Code § 14.4(d). That too is highly burdensome.

Finally, employers must provide annual reports to the City. § 14.3(b); OLSE Reg. No. 7.3. If employers satisfy the health care expenditure requirements by making payments to the City, they must also provide quarterly reports to covered employees. OLSE Reg. No. 7.1. These requirements likewise increase an employer's administrative burdens.

C. Covered Employers Are Subject To The Ordinance's Enforcement Scheme Separate And Apart From Their Obligations Under ERISA.

Additional burdens arise from the Ordinance's enforcement scheme. Employers are subject to audit at any time. OLSE Reg. No. 7.4. The Enforcement Office is authorized to issue and adjudicate administrative complaints, remedy violations, and issue penalties ranging from $25 per day to $1000 per employee per week of non-compliance, plus interest. OLSE Reg. No. 9.1-9.3. The determination of the Enforcement Office may be appealed to an administrative hearing officer. OLSE Reg. No. 10.1-10.3. The administrative hearing officer's decision may be reviewed by the San Francisco Superior Court. OLSE Reg. No. 10.3(D).

In sum, the administrative burdens imposed by the Ordinance at issue here represent an enormous

increase in the costs of administering ERISA-regulated employee benefit plans. And they are precisely the kinds of burdens that the ERISA's broad preemption provision was designed to prevent.

II. Unless The Court Acts Now, The Burden On Employers In Providing Health Care Benefits To Employees Will Expand Exponentially As Other State And Local Governments Enact Their Own Health Care Mandates.

If other states and localities are permitted to follow the Ninth Circuit's "roadmap," sponsors of nationwide ERISA plans will confront an array of new requirements affecting contributions and administration. For each jurisdiction implementing its own "pay-or-play" law, the employer will have to determine: (i) whether it is subject to the law; if so (ii) which employees are covered; (iii) what contributions are required; (iv) the extent to which its current plan(s) entitle it to offsets; (v) how to treat employees who may be covered by more than one jurisdiction's mandates; (vi) what records it must keep; and (vii) what reporting is required. Presumably, each jurisdiction will have its own enforcement mechanisms.

Even the most casual analysis of some of the recently proposed "pay-or-play" laws demonstrates, first, that countless additional "pay-or-play" laws will be enacted swiftly by state and local governments if the Ninth Circuit's decision is allowed to stand, and second, that this flood of mandates will place a crushing burden of inconsistent regulation on plan sponsors seeking to provide health care benefits to their employees.

A. States And Localities Already Have Considered Scores Of "Pay-Or-Play" Laws.

The mere number of "pay-or-play" laws that have been proposed attests to the likelihood that such laws will be enacted swiftly if the Ninth Circuit's decision is allowed to stand. As of 2006, more than fifty "pay-or-play" bills had been introduced in twenty-eight state legislatures alone. Julia Contreras and Orly Lobel, *Wal-Martization and the Fair Share Health Care Acts*, 19 St. Thomas L. Rev. 105, 136 (2006). All of these bills sought to impose mandates on employers to pay for employee health care, but beyond this, the bills display a wide range of differences.

B. The Compliance Obligations Of Nationwide Employers Will Expand Dramatically As State And Local "Pay-Or-Play" Laws Are Enacted.

As "pay-or-play" laws take root, employers will be required to constantly assess whether they are subject to such laws in any jurisdiction in which they do business. For example, the Ordinance here covers for-profit employers engaged in business in San Francisco that employ twenty or more persons anywhere in the country. OLSE Reg. No. 2.2(A), (C). Other proposals vary from as few as ten employees to as many as ten thousand. Contreras at 136. Employers below the threshold would, of course, have to monitor all such laws to stay informed of changes in the applicable thresholds, as well as their own employee numbers, to know when coverage may be triggered.

Employers subject to state and local mandates would also have to determine which of their employ-

ees are covered under each jurisdiction's law. As previously explained, determining whether an employee is "covered" in San Francisco involves a detailed, fact-specific inquiry. Various proposals in other states have embraced different definitions, some classifying "employees" as all individuals employed full- or part-time by the covered employer.[3] A Florida proposal cross-referenced other state law definitions of "employee."[4] A Virginia bill did not define "employee" at all.[5] New Jersey's initiative limited "employees" to those working within the State.[6] New York City's definition includes any full-time, part-time, or seasonal employee, but excludes family members and persons "hired to work exclusively for the holiday period from November 1 through December 31."[7] Thus, employers would have to engage in detailed analyses to determine which of their employees might be covered by *every* such law, and monitor *all* of them for changes.

Some of the widest variations in state and local proposals involve a concern central to the provision of ERISA benefits—how to calculate employer health care spending requirements. In contrast to San Francisco's plan, which uses only covered employees

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[3] *See e.g.*, H.R. 1703, 2006 Leg., Reg. Sess. (N.H. 2006); Sen. 2684, 2006 Leg., Reg. Sess. (Miss. 2006).

[4] Sen. 1618, 2006 Leg., Reg. Sess. (Fla. 2006).

[5] H.D. 258, 2006 Leg., Reg. Sess. (Va. 2006).

[6] A. 2513, 212th Leg., 2007-2008 Sess. §2 (N.J. 2006). *See also* A. 1966, 213th Leg., 2008-2009 Sess. (N.J. 2008).

[7] N.Y.C. Admin. Code §22-506(b)(6).

in the expenditure formula, several state proposals would require contribution amounts to be determined as a percentage of the employer's overall payroll, varying from six to eleven percent.[8] A Virginia proposal would require employers to pay "the statewide average of the percent of wages that was spent on employee health insurance costs by all employers with 250 or more employees in the Commonwealth, as determined by the Commissioner."[9] A Wisconsin proposal would require employers to cover all employers and pay at least eighty percent of the cost of that coverage, or else pay "an assessment that is equal to the cost incurred by society as a result of the employer not providing that coverage" – a cost that would be calculated "using the methodology promulgated" by the State.[10] Employers undoubtedly would be subject to a wide variety of contribution mandates applicable to different employees.

Employers wishing to comply with "pay-or-play" laws by "playing"—i.e., paying into their existing ERISA plans—would have to determine for each jurisdiction whether their required health care spending requirements can be offset by benefits they provide through existing ERISA plans. The San Francisco Ordinance counts toward an employer's "Qualifying Health Care Expenditures" any tax deductible medi-

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[8] 19 St. Thom. L. Rev. at 136. *Cf.* H.D. 4024, 2006 Leg., Reg. Sess. (W.Va. 2006), H.R. 1316, 65th Gen. Assem., 2d Reg. Sess. (Colo. 2006).

[9] H.D. 258, 2006 Leg., Reg. Sess. (Va. 2006).

[10] A. 860, 2005-2006 Leg., 2005 Reg. Sess. (Wis. 2005) § 2.3(A)(1).

cal care expenses, "or goods having substantially the same purpose or effect as such deductible expenses." OLSE Reg. Nos. 4.1(A), 4.2, 4.3. A 2007 Michigan proposal had a similar standard, but would not have counted spending with "substantially the same purpose or effect."[11] Florida's proposal contained no limitation on tax deductible spending.[12] Washington's proposal keyed its definition of "health care services expenditures" to state law, rather than the federal Tax Code.[13] Employers would have to determine what portion of the benefits they provide through national ERISA plans (and otherwise) would qualify under *each* jurisdiction's varying definitions.

The advent of state and local "pay-or-play" laws also creates the potential for conflicting obligations as to the same employees. Sponsors of nationally administered ERISA plans will likely employ personnel who fall within the "covered employee" definition of multiple jurisdictions. For example, a delivery driver based in Oakland will be subject to San Francisco's Ordinance if he makes a sufficient number of deliveries in San Francisco. OLSE Reg. No. 3.1(C)(1). But if Oakland enacts its own ordinance, the employer may be subject to the requirements of both jurisdictions with respect to the *same* delivery driver. Under the San Francisco Ordinance, payments made on behalf of the employee to Oakland apparently would not constitute health care expenditures entitling the employer to a setoff against the spending requirements

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[11] Sen. 87, 2007-2008 Leg. Sess., Reg. Sess. (Mich. 2007).

[12] Fla. Sen. 1618 §1.1(e).

[13] H.R. 2517, 59th Leg. 2006 Reg. Sess. (Wash. 2006).

of the San Francisco Ordinance. *See* OLSE Reg. No. 4.2(B) ("health care expenditures shall not include any payment made directly or indirectly to obtain...any other coverage required by any other local, state, or federal law.") Such conflicts likely will riddle a regulatory scheme that consists of scores (or hundreds) of uncoordinated state and local laws.

C. Employers' Record-Keeping And Reporting Obligations Will Also Expand Dramatically.

In addition to complying with the spending mandates of all the applicable local laws, employers will have to comply with a wide array of record-keeping requirements. In the aggregate, these requirements will add to the cost of providing benefits and frustrate plan sponsors' provision of a nationally uniform scheme.

For example, the New York City Ordinance would require plan sponsors to maintain "an accurate work log that includes, for each employee, such employee's name, trade or occupation, and the dates and hours or time periods worked by such employee" and "accurate records of health care expenditures and required health care expenditures." N.Y.C. Admin. Code § 22-506(c)(3).

Employers will also have to comply with the reporting and enforcement provisions of the many new laws. One typical proposal linking spending mandates to the employer's payroll would require annual reporting, *inter alia*, on: (1) how many employees were eligible to receive health care expenditures; (2) how many received them from the employer, (3) how much the employer spent on all health care expenditures; and (4) what percentage of payroll those ex-

penditures represented.[14] Another proposal would require:

> A description of the health care coverage provided by the employer, together with the total cost of that coverage, excluding any deductibles and co-payments that may be required under the employer's group health insurance plan, and a breakdown of the amount of that total cost that is paid by the employer and the amount of that total cost that is paid by the employer's employees.[15]

Any administrative economies of scale that national plan sponsors may be able to exploit would be undermined by the imposition of new statutory and regulatory requirements, as well as varying interpretations of similar record-keeping and reporting requirements, from jurisdiction to jurisdiction.

Finally, failure to comply with reporting requirements, cooperate with auditing agencies, allow reasonable access to records or maintain and retain accurate records could expose an employer to penalties. *See e.g.*, OLSE Reg. No. 9.2(A). Proposed fines vary from San Francisco's penalty of $25 to $500 per violation per day (*id.*), to Wisconsin's sanction of up to $250 per day[16], to Florida's $1000 fine for each day a report goes unfiled.[17] Presumably, each new law will include its own audit and enforcement require-

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[14] Fla. Sen. 1618 §§ 1.4(a)(1)-(5).

[15] Wis. A. 860 § 2.2(a)(2).

[16] Wis. A. 860 § 2.4(a).

[17] Fla Sen. 1618 § 1.7(a).

ments.[18] And these will only add to the crushing, cumulative impact of similar laws enacted in other jurisdictions.

III. "Pay-Or-Play" Laws Are Preempted Because Their Cumulative Impact Will Undermine The Uniform Administration Of Employee Benefits That Is A Hallmark Of Erisa And Will Likely Force Employers To Amend Their Existing Plans.

These burdens powerfully reinforce the district court's conclusion that the Ordinance here—and others like it—is preempted by ERISA. As this Court has observed, "[o]ne of the principal goals of ERISA is to enable employers 'to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits' . . . [u]niformity is impossible, however, if plans are subject to different legal obligations in different states." *Egelhoff* v. *Egelhoff*, 532 U.S. 141, 148 (2001). That is one of the main reasons that ERISA broadly preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA. 29 U.S.C. § 1144(a). This Court has repeatedly confirmed that ERISA preemption is "expansive." *Egelhoff*, 532 U.S. at 146, *citing New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645, 655, (1995).

In analyzing whether state or local laws impose a prohibited burden on benefit plans, the Court also takes account of the *cumulative impact* on the ad-

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[18] *Cf.* OLSE Reg. No. 8, N.Y.C. Admin. Code § 22-506(i)(1).

ministration of such plans if a particular type of local regulation were allowed. *Egelhoff*, 532 U.S. at 151. As we now show, "pay-or-play" laws such as the one at issue here are preempted by ERISA, both standing alone, and because of their likely cumulative impact.

1. There can be no doubt that Congress intended ERISA preemption to "eliminate the threat of conflicting [and/or] inconsistent State and local regulation." *Shaw* v. *Delta Air Lines Inc.*, 463 U.S. 85, 99 (1983) (quoting statements by Representative Dent and Senator Williams, ERISA's sponsors in the House and Senate, 120 Cong. Rec. 29197 (1974); 120 Cong. Rec. 29933 (1974)). In *Fort Halifax Packing Co, Inc.* v. *Coyne*, 482 U.S. 1, 9 (1987), the Court recognized that statements on this issue by ERISA's sponsors "reflect recognition of the administrative realities of employee benefit plans." And the Court explained with care *why* Congress sought to minimize the risk of state and local regulations that would vary from ERISA's requirements:

> An employer that makes a commitment systematically to pay certain benefits undertakes a host of obligations, such as determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping appropriate records in order to comply with applicable reporting requirements. The most efficient way to meet these responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits. Such a system is difficult to achieve, however, if a benefit plan is subject to differing regulatory require-

> ments in differing states. A plan would be required to keep certain records in some states but not in others; to make certain benefits available in some states but not in others; to process claims in a certain way in some states but not in others; and to comply with certain fiduciary standards in some states but not in others.

Id. *See also Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133, 142 (1990); *Egelhoff*, 532 U.S. at 148.

The focus on the need for a uniform body of law rather than a "patchwork quilt" of state and local regulations permeates this Court's ERISA jurisprudence. It emphasizes a pragmatic analysis of the actual effect of state and local laws upon ERISA's overarching goal of ensuring uniform administration of covered benefit plans. *See id.*

2. Under any pragmatic analysis, the Ordinance itself subjects a covered employer to substantial regulatory requirements that are different from, and in addition to, ERISA, in the financing and provision of health care benefits to covered employees. The Ordinance requires that benefits be made available to employees working in San Francisco, but not other places. In addition, as explained above, it requires employers to keep records that are not required by ERISA. It has its own enforcement process culminating in state court oversight, but without requiring compliance with ERISA's fiduciary standards.[19] The

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[19] An ERISA fiduciary must discharge his duties solely in the interest of plan participants and beneficiaries. 29 U.S.C. § 1104(a). Yet under the Ordinance, the San Francisco City Controller may appropriate contributions made on behalf of employees to the Program in some circumstances. S.F. Admin. Code § 14.2(h).

Ordinance thus imposes a mandated and self-contained system of employee benefit regulation specific to "San Francisco" employers and employees—*precisely* the type of local regulation of employee benefit plans that ERISA's broad preemption provision was intended to prevent.

The Ninth Circuit attempted to sidestep these concerns by asserting that the Ordinance impacts employers, not plan administrators. Pet. at 32a. But this distinction finds no support in this Court's ERISA preemption jurisprudence. As noted above, this Court has consistently recognized that one purpose of ERISA is to encourage *employers* to make a commitment systematically to provide benefits for their employees. *See, e.g., Coyne,* 482 U.S. at 9. Accordingly, ERISA preemption intentionally makes "plan sponsors"—*i.e.,* employers—as well as plan administrators, subject to a uniform system of laws to minimize the overall administrative and financial burden accompanying the provision of employee benefits. Congress created that regime recognizing that inefficiencies created by uncoordinated and potentially inconsistent state and local laws would ultimately work to the detriment of plan beneficiaries.

Whether these inefficiencies burden employers, plan administrators, or both, their effect is the same. They make it more costly and difficult to provide employee benefits, and therefore, work to the detriment of plan beneficiaries. The Ninth Circuit's attempt to distinguish between employers and plan administrators thus creates a distinction without a difference.[20]

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[20] The Ninth Circuit's reliance upon *Keystone Chapter, Associated Builders & Contractors, Inc.* v. *Foley,* 37 F.3d 945, 960 (3d Cir. 1994), and *WSB Electric, Inc.* v. *Curry,* 88 F.3d 788, 793

3. If San Francisco's ordinance, standing alone, would contravene ERISA's preemption provision – and it does—it is obvious that allowing a wide array of state and local "pay-or-play" laws would impose a very substantial burden on the financing and administration of health care benefit plans. One could hardly imagine a more complex and inefficient way of maintaining "a uniform system of employee benefit laws" aimed at encouraging employers to provide benefits voluntarily than to have scores of uncoordinated state and local "pay-or-play" laws.

In that regard, these laws create a problem even more serious than the one the Court faced in *Egelhoff*. There, the Court invalidated a law that deemed an election of a spouse during marriage to be invalid if the insured and the beneficiary subsequently divorced because such a law, if not preempted, would require plans to monitor the laws of 50 states to determine whether other similar laws might impact a beneficiary determination. 532 U.S. at 148. Here, by contrast, if the San Francisco Ordinance is valid, employers will have to monitor the laws of 50 states and 30,000 localities to determine whether they are subject to complex benefit contribution mandates implemented in countless ways, creating different re-

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(9th Cir. 1996), is misplaced. Both *Keystone* and *Curry* involved "prevailing wage" laws. *Id.* As the district court recognized below, employers subject to the program in *Curry* could satisfy their prevailing wage obligation in whole or in part simply by *paying wages to employees* at the appropriate rate. App. 100a-102a (citing *Curry*, 88 F.3d at 793-96); *see also Keystone*, 37 F.3d at 960. The Ordinance is different. It requires employers to *procure healthcare benefits* for employees. They therefore are not "benefits neutral," as the courts in *Keystone* and *Curry* found the prevailing wage laws to be.

quirements for different employees, if not inconsistent obligations for the same employees. They will be subject to ongoing record-keeping and reporting requirements, audits, and potentially enforcement proceedings. It cannot credibly be disputed that the cumulative burden of such laws would undermine the uniformity of employee benefit law in a far more fundamental and burdensome way than the law at issue in *Egelhoff*.

4. The resulting patchwork of state and local regulations would also likely force employers to amend their existing plans—another basis for finding ERISA preemption. *See Ingersoll-Rand*, 498 U.S. at 142 (ERISA preempts laws that require the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction). To be sure, the Ninth Circuit reasoned that ERISA does not preempt the Ordinance because employers are not "required" to alter their plans. Pet. 29a-30a. Yet it is inevitable that most, if not all, plans *will* be altered as employers become subject to an ever-increasing array of "pay-or-play" laws.

One option will be to decrease health care benefits in places where there are no mandates—which in turn will create pressure to implement mandates in these locations. Another strategy will be to reduce other kinds of benefits, like pension benefits, that states and localities have not (yet) required employers to fund. In either case, plans will be altered.

Even employers who simply absorb the added cost of the new mandates and their associated administrative burdens will alter their plans as they seek to ensure that all their employees receive comparable benefits. That undoubtedly will be a complex task for

large employers who become subject to multiple "pay-or-play" laws. Yet it is highly unlikely that employers will myopically continue to fund their benefit plans without making any alternations to them, as an increasing number of state and local laws may impose countless mandates and regulations.

In short, it is obvious that the Ordinance, and the cumulative sum of the laws it will precipitate if the Ninth Circuit's decision stands, will cause the wholesale alteration of employer-sponsored plans, as employers seek to adjust their benefit packages in the new world of local health care regulation. That was the conclusion of the Fourth Circuit in *Retail Industry Leaders Association* v. *Fielder*, 475 F.3d 180, 196-97 (4th Cir. 2007) ("[i]f Wal-Mart were to attempt to utilize non-ERISA health spending options to satisfy the Fair Share Act, it would need to coordinate those spending efforts with its existing ERISA plans"). And it remains true today.

CONCLUSION

The Ninth Circuit's reasoning fails to account for the cumulative real-world impact that the Ordinance, and others that will follow in its wake, will have on employer sponsored benefit plans.

To be sure, it is impossible to predict *exactly* how the provision of health care benefits and the delivery of health care will change if "pay-or-play" laws are allowed to take root, let alone the impact that such a sea change in health care regulation may have on the national economy. It is clear, however, that allowing the Ninth Circuit's decision to stand will not simply delay the resolution of the problem posed by the San Francisco Ordinance and laws like it. Allowing the

decision to stand, even for a short time, will exacerbate the problem exponentially.

The petition should be granted.

Respectfully submitted,

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In The
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GOLDEN GATE RESTAURANT ASSOCIATION,

Petitioner,

v.

CITY AND COUNTY OF SAN FRANCISCO,

Respondent,

SAN FRANCISCO CENTRAL LABOR COUNCIL; SERVICE EMPLOYEES INTERNATIONAL UNION ("SEIU"), LOCAL 1021; SEIU UNITED HEALTHCARE WORKERS-WEST; and UNITE HERE! LOCAL 2,

Intervenors/Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF FOR ZAZIE AND MEDJOOL RESTAURANTS AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

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QUESTION PRESENTED

San Francisco's universal health care ordinance contains two interlocking components: a comprehensive public health care program available to all uninsured residents at sliding scale fees, and a general health care spending requirement for medium and large employers. Employers may comply with the spending requirement either through their own health care plans, or by paying into the public program. If employers choose the public option, their employees receive a substantial discount on the health care services available through that program. The question presented is:

Does ERISA preempt the portion of San Francisco's universal health care ordinance that imposes a general health care expenditure requirement on medium and large employers, where every employer may readily comply without adopting an ERISA plan or altering an existing plan, and where the option of paying into the public program is a rational choice for employers rather than a penalty?

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Supreme Court Rule 37.6 1

INTEREST OF *AMICI CURIAE*[1]

The San Francisco Health Care Security Ordinance ("Health Care Ordinance" or "ordinance"), S.F. Admin. Code §14 *et seq.*, levels the economic playing field for businesses that wish to provide health insurance coverage for their employees. Without the Health Care Ordinance, restaurants that aspire to cover their employees would be forced to abandon their health care benefits or be driven out of business because of the difficulty in competing with other restaurants that do not spend money on health care. The Golden Gate Restaurant Association ("GGRA" or "Petitioner") does not represent the interests of all the restaurants in San Francisco, nor does it embody the interests of restaurant employees, taxpayers, and the restaurant-going public. Indeed, *amicus* Medjool is a member of the GGRA but disagrees with the GGRA's position in this case.

The Health Care Ordinance serves the interests of *amici curiae*, Zazie and Medjool, medium-sized restaurants in San Francisco, because it enables these restaurants to act responsibly by providing health insurance coverage for employees while

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[1] Pursuant to Supreme Court Rule 37.6, no counsel for a party authored this brief in whole or in part, and no person or entity other than *amici curiae* made a monetary contribution intended to fund the preparation and submission of this brief. *Amici* notified counsel of record for each party in a timely manner 10 days prior to filing, and letters of consent have been filed with the Clerk of the Court.

maintaining their ability to compete economically. The ordinance further serves the interests of Zazie and Medjool by enabling the restaurants to protect the health of both employees and customers, by ensuring that employees have access to affordable health care services, and by helping to prevent episodes of food contamination by ill employees. *Amici* believe that not only is the ordinance in their own interest but it is in the interest of all restaurants and San Francisco residents, because it allows businesses to compete in a fair and level context while also ensuring that all San Francisco workers have access to affordable health care.

This brief grounds its arguments in the real-world experience of Zazie. Medjool joins the brief because it too supports the Health Care Ordinance and disagrees with GGRA's stance. The arguments set forth on behalf of Zazie apply equally to Medjool, with the minor difference that Medjool, which already provided health insurance for its full-time employees before the ordinance took effect, now also pays the City for the rest.

STATEMENT

Zazie is a neighborhood restaurant in San Francisco and a medium-sized[2] "covered employer" as

[2] A "medium-sized" business means a business with at least twenty employees. S.F. Admin. Code §14.1(b)(3), (b)(12); OLSE

(Continued on following page)

defined in the Health Care Ordinance and the Office of Labor Standards Enforcement (OLSE) Regulations Implementing the Employer Spending Requirement of the San Francisco Health Care Security Ordinance. S.F. Admin. Code §14.1(b)(3) *et seq.*; OLSE Reg. No. 2.

The Health Care Ordinance, passed in July 2006, has two central components: Healthy San Francisco, a city-administered health care program that provides access to health care services for specified San Francisco residents, and a mandatory employer health care expenditure requirement. This expenditure requirement covers all employees who work more than eight hours a week and is pro-rated by hours worked, based on a forty-hour work week. S.F. Admin. Code §14.1(b)(2)(c). Covered employers like Zazie must spend at least $1.23 or $1.85 (depending on employer size) on health care for each hour paid to each of their covered employees on a quarterly basis. S.F. Admin. Code §14.1(b)(8)(b).[3] Employers may spend the funds directly on health care services or pay into San Francisco's program. S.F. Admin. Code §14.1(b)(2); OLSE Reg. No. 3.

Reg. No. 2.2(A)(1), (C)(2). Businesses with fewer than twenty employees are considered "small" businesses and are exempt from the Health Care Ordinance. S.F. Admin. Code §14.1(b)(15); OLSE Reg. No. 2.2(C)(3).

[3] In 2010, the rate will increase to $1.31 for medium-sized employers. S.F. Admin. Code §14.1(b)(8)(c).

The calculation, which involves multiplying hours by $1.23, is straightforward. Zazie's covered employees work approximately 7,500 hours per quarter so, to comply with the ordinance, the restaurant must spend just over $9,225 per quarter ($1.23 x 7,500), or $36,900 per year, on health care. Zazie is permitted to average its expenditures over employee hours worked because it offers uniform health coverage to its employees. *See* OLSE Reg. No. 6.2(B)(1).

Zazie complies with the health care spending requirement by providing health insurance for its employees through a Kaiser Permanente ("Kaiser") managed care plan for which it pays approximately $50,000 in annual premiums for covered employees. The restaurant easily covers these payments through a $1 surcharge for every restaurant customer.

The Golden Gate Restaurant Association (GGRA) filed suit in 2006 to block the ordinance's employer expenditure requirement on the grounds that it is preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §1001, *et seq.*, and has now petitioned for a writ of certiorari in an attempt to undercut the progress made in San Francisco since the implementation of the ordinance in January of 2008.

SUMMARY OF ARGUMENT

What motivates the GGRA and its allies is a desire to avoid spending money on providing health care to low-wage employees. Because they cannot reasonably argue that ERISA prevents local governments from enacting general employer expenditure requirements, Petitioner its *amici* instead make greatly exaggerated arguments about the administrative requirements associated with the Health Care Ordinance. Despite parties having had full opportunity for discovery, the record contains no evidence of any burden that would support Petitioner's position, rendering this case a flawed vehicle for consideration of Petitioner's arguments.

This brief sets forth the real-world experience of a San Francisco restaurant, Zazie, which supports the Health Care Ordinance. Zazie credits the ordinance for allowing it to offer health insurance to its employees without being undercut by competitors that do not want to share the responsibility for the well-being of their workers. Zazie's stance is not atypical. In a recent survey by Small Business Majority California, the overwhelming majority (80%) of business owners employing fewer than 100 employees expressed support for employer contributions to employee health care.

Zazie's positive experience with the Health Care Ordinance belies Petitioner's arguments and underscores the *de minimis* nature of the administrative tasks involved in compliance. Moreover, while

Petitioner and its allies engage in a speculative exercise about how difficult it might be for employers to comply with hypothetical copycat ordinances that might some day pass in other jurisdictions, Zazie presents evidence about what employers in San Francisco actually do. Zazie's experience demonstrates that even if similar ordinances were to pass elsewhere, employers would have little difficulty complying, just as they currently routinely comply with disparate minimum wage, tax, leave, and other laws.

ERISA was never intended to shield employers from mere expenditure requirements. ERISA was born of a legislative compromise that incorporated a preemption provision into what remains at heart a worker protection law.[4] But Petitioners push for an imbalanced reading of ERISA in which the reach of such preemption would extend beyond what Congress intended. ERISA's concerns about uniformity are limited to protecting employers from the expense and inconvenience of having to alter their employee benefit plans, not to eliminate the possibility that employers might have to tweak their payroll process slightly to comply with laws that require minimum

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[4] As explained in *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., Inc.*, 519 U.S. 316, 326-327 (1997), "[i]n enacting ERISA, Congress' primary concern was with the mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits from accumulated funds."

expenditures on employee benefits. *See, e.g., N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 657, 661 (1995); *Massachusetts v. Morash*, 490 U.S. 107, 108 (1989); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 100 n.21 (1983). The Health Care Ordinance's expenditure requirement and the minimal administrative steps involved in complying are permissible under ERISA.

For these reasons, the Court should deny the petition.

ARGUMENT

I. COMPLYING WITH THE HEALTH CARE ORDINANCE IS EASY AND LEAVES ROOM FOR EMPLOYER CHOICE.

The mere fact that a law regulating employee benefits creates administrative requirements on employers does not subject it to federal preemption. *WSB Elec., Inc. v. Curry*, 88 F.3d 788, 795 (9th Cir. 1996). To the extent Petitioner argues that the Health Care Ordinance is preempted because it imposes burdensome recordkeeping, reporting, and other administrative requirements on employers, however, it must produce evidence in support of that argument. It has failed to do so. Nothing in the record suggests that complying with the ordinance is either burdensome or difficult. Thus, this factual record would not provide a basis for the Court to decide whether a

law may be preempted by ERISA based on employer administrative requirements.

A. Complying with the Health Care Ordinance Involves Minimal and Simple Administrative Tasks.

Through misleading and theoretical arguments, Petitioner and its *amici* greatly exaggerate the administrative requirements associated with the Health Care Ordinance. Zazie's actual responsibilities under the ordinance are straightforward and not time-consuming.

Threshold coverage determinations, which Petitioner mischaracterizes as complex, are in fact simple. When the Health Care Ordinance went into effect, Zazie's owner knew the restaurant was a "covered employer:" it typically employs a staff of thirty, more than the twenty employee threshold. S.F. Admin. Code §14.1(b)(12); OLSE Reg. No. 2.2(A), (C)(2). Two of Zazie's employees, the General Manager and the Chef, are deemed managerial under California and federal law and therefore fall under the ordinance's "managerial, supervisorial, or confidential" exemption. S.F. Admin. Code §14.1(b)(2)(d); *see* IWC Wage Order, 8 C.C.R. §11050(1)(B)(1); 29 C.F.R. §541.201. The rest are hourly employees clearly covered by the ordinance. When the ordinance went into effect, Zazie – which was already providing insurance to the two salaried employees who would have been exempt – ascertained which hourly

employees received health care services from another source and purchased a Kaiser plan for the rest.

The process for new employees is equally straightforward. Zazie calendars the new employee's health insurance start date ninety days after the date of hire. S.F. Admin. Code §§14.1(b)(2), 14.3(a); OLSE Reg. Nos. 3.1(A)(2), 6.1(B). Zazie's owner likens it to calendaring the end of a probationary period and appreciates the ninety day window for that reason. When the period ends, Zazie completes a one-page health insurance enrollment form, faxes it to Kaiser, and the new employee's insurance starts on the first of the following month.

Tracking hours worked is not difficult. Like any other employer, Zazie records employee hours worked for payroll purposes. Zazie uses a computerized time clock. Employees swipe their time card when they start and stop work, and the data go directly to Zazie's computer. Like all San Francisco restaurants Zazie's owner knows, Zazie uses a payroll company to process its bi-weekly payroll. Zazie reports employee hours worked to its payroll company, ADP, which for a small fee provides an array of services. The need for these services predates the Health Care Ordinance and the ordinance has not caused the payroll processing fee to increase. ADP ensures compliance with the latest regulations regarding federal, state, and local taxes, calculates Zazie's payroll with appropriate deductions and withholdings for all jurisdictions, notifies the state as required concerning new hires, prepares paychecks, manages Zazie's Unemployment

Insurance, calculates and reports back Workers' Compensation premiums, calculates and produces W2s and 1099s, and sends Zazie updated federal and state labor law posters. ADP also allows online access to comprehensive pay histories and provides a quarterly report to Zazie showing individual and gross employee hours worked. This report is the only payroll data required to comply with the ordinance and Zazie needs it for pre-existing purposes. *See, e.g.*, Cal. Labor Code §226. Zazie treats payroll services as a business necessity and the Health Care Ordinance has not prompted any change in its practice or additional payroll expense.

Tracking how much Zazie spends on employee health care each month has proven equally straightforward. Zazie receives a monthly bill from Kaiser that shows the total premium owed, with a breakdown by employee. Zazie mails a premium check to Kaiser and files the stub with the Kaiser bill. Zazie keeps records of all health care expenditures using QuickBooks accounting software, which it also used before the ordinance went into effect. When Zazie pays for other health care services, such as occasional chiropractic care for its employees, Zazie tracks, records and files those expenditures in the same way. Every quarter, Zazie need only compare its quarterly health care expenditures to the required level to

know it has complied with the Health Care Ordinance.[5]

The Health Care Ordinance is an exceedingly simple expenditure requirement. For employers that, like Zazie, provide uniform health coverage to their employees, the ordinance merely requires that the "*average* expenditure rate per employee" meet or exceed the employer expenditure requirement. OLSE Reg. No. 6.2(B)(1) (emphasis supplied). In other words, to determine the amount it must spend on health care services, after subtracting the hours of ineligible or exempt employees,[6] Zazie must simply multiply the quarterly number of hours its employees worked, as reported by ADP, by $1.23. This calculation takes less than five minutes and Zazie could ask ADP to do it.[7] Zazie then compares the required

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[5] Had Zazie chosen to pay into Healthy San Francisco, instead of verifying that the Kaiser premiums and other expenditures meet the legal requirement, Zazie would simply calculate its required expenditure level and mail a quarterly check to the City of San Francisco. This is what Medjool does.

[6] Ineligible or exempt employees include those who have not yet been employed for ninety days, who work fewer than eight hours per week, or who waive the expenditure requirement because they are receiving health care services through another employer. S.F. Admin. Code §14.1(b)(2), (b)(2)(c); (b)(2)(h); OLSE Reg. No. 3.1(A)(2), 3.1(A)(3)(b), 3.2(A)(5).

[7] Because full-time employees and part-time employees have slightly different health plans with different co-payments, Zazie must perform the calculation twice. This is also true for Medjool, which provides Kaiser coverage for some employees and pays the City for the rest. This adds an insignificant amount of time and effort.

expenditure to the amount it actually spends on employee health care. If Zazie were spending less than required, it would pay the difference to the City of San Francisco, which would entitle Zazie's employees to additional benefits through the City's program. Because Zazie consistently spends more than required, it need do nothing other than report compliance annually.

Reporting takes Zazie no more than thirty minutes per year. Every year, the City of San Francisco mails Zazie a simple, one-page Mandatory Annual Reporting form (App. 1) that asks how many hours the restaurant's employees worked, and how much it spent on health care for them. Zazie returns the form with its annual business registration submission to the City. *See* S.F. Admin. Code §14.3(b); OLSE Reg. No. 7.3. That is all Zazie need do to comply.

B. The Health Care Ordinance Overlaps with and Requires Less Effort than Other Existing Labor and Employment Laws.

Amicus Washington Legal Foundation's approach is to break down each element of compliance into enough detail to crush the spirit of any entrepreneur. But this obfuscates the real-world context in which the Health Care Ordinance operates and misleads the Court. All across America and in San Francisco, medium-sized business owners comply with myriad

labor and employment laws, many of them far more onerous than the Health Care Ordinance, and many of which already require the same records.

As a business owner, Zazie's owner is accustomed to complying with and keeping up to date with multiple laws, including federal, state and local tax laws and minimum wage laws. These laws all require calculations, record keeping, and reporting. Zazie also pays and tracks contributions to employee benefits such as Worker's Compensation and an employee 401(k) plan. As a restaurant, Zazie must also comply with a host of other local, state, and federal laws, including Occupational Safety and Health Administration (OSHA) standards and California Department of Public Health Food Safety Program regulations and guidelines. Taken in the context of the responsibilities medium-sized business owners routinely accept, adhering to the minimal requirements of the Health Care Ordinance is no burden.

Comparing quarterly hours worked to health care expenditures is no more burdensome than fulfilling the requirements of other laws. The San Francisco Minimum Wage Ordinance, for example, requires businesses to document hours worked, maintain payroll records for four year periods, and allow the City to monitor compliance. *See* S.F. Admin. Code §12R.5(c). Moreover, Zazie already records its employees' hours to comply with the Minimum Wage Ordinance and other laws. Keeping track of health care expenditures is also independently required in order to qualify for the federal income tax exclusion

for employer-provided health insurance, Internal Revenue Code, 26 U.S.C. §106(a).

Zazie has only one location, but restaurants with multiple locations routinely comply with other regulations that differ from jurisdiction to jurisdiction, including for employees who work in more than one location. *See, e.g.,* S.F. Admin. Code §12R; Oakland Mun. Code §2.28.030 (differing minimum wage ordinances in the neighboring cities of San Francisco and Oakland).

Considered in the context of the other laws with which Zazie must comply, the Health Care Ordinance adds insignificant administrative responsibilities.

C. The Health Care Ordinance Gives Zazie Choice and Flexibility.

The Health Care Ordinance gives employers a broad range of choices: pay the City of San Francisco to fund employee participation in the Health Access Program (Healthy San Francisco) or medical reimbursement accounts, purchase private insurance coverage, direct expenditures into a self-funded plan, contribute to health savings or reimbursement accounts, reimburse employees for health care services received, or deliver health care services directly. OLSE Reg. No. 4.2(A). Zazie provides direct coverage to its employees through a Kaiser health plan.

Not only does the ordinance give Zazie a choice of how to comply, it also allows employers like Zazie to

tailor benefits to the needs of their employees. With advice from the insurance broker who provides Zazie's liability and umbrella coverage, Zazie elected to cover the restaurant's employees through Kaiser. Because the staff is young and healthy but has limited savings, Zazie chose a comprehensive plan with relatively high co-payments ($30 for full-time employees and $50 for part-time employees) but a $1500 cap on out-of-pocket payments. Zazie pays just over $50,000 for this coverage. After one year, Zazie found that the $1 per customer surcharge was more than enough to cover the Kaiser premiums, so in April 2009 Zazie added dental insurance. The Health Care Ordinance gives Zazie the flexibility to make coverage decisions as it pleases.

The economic impact of the recession caused Zazie to consider paying into Healthy San Francisco instead of continuing the Kaiser coverage though Zazie's owner ultimately decided to keep the Kaiser plan. Zazie finds both options equally simple, and sees no obstacle to switching between them.[8]

Many other medium-sized business owners chose to pay into Healthy San Francisco because it was the cheaper option. Indeed, midway through 2008 over 700 employers had chosen to pay into the city plan,

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[8] Indeed, Medjool has chosen to provide a Kaiser plan to some employees and pay the City for others.

contributing $26 million on behalf of 31,000 workers.[9] Other restaurant owners opened Health Reimbursement Accounts for their employees. Congress did not intend ERISA to preempt an ordinance that, similar to a minimum wage law with a benefits component, simply sets a floor for health care expenditures while giving employers choice and flexibility.

II. THE ORDINANCE BENEFITS THE PUBLIC AND PROTECTS WORKERS WHO RISK LOSING THEIR HEALTH AND EVEN THEIR LIVES WITHOUT IT.

Zazie's staff is young and healthy but in 2008 an employee who had been with the restaurant for almost a decade called in sick because his stomach hurt. Having only ever received uncompensated care at the public hospital, he questioned what he should do with the Kaiser card Zazie had given him. Moreover, based on previous, negative encounters with the health care system as an uninsured patient, he was loath to go to Kaiser. When his pain drove him to seek care at the Kaiser hospital anyway, he was admitted immediately with appendicitis. He had brought with him $6000 of his personal savings in cash, because he feared he would have to pay upfront for his medical care as a condition of treatment. Because he had

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[9] Mitchell Katz, Nat'l Acad. for State Health Policy and State Coverage Initiatives, *Providing Universal Access to Care: Healthy San Francisco* (2009), *available at* http://www.nashp.org/files/ERISAwebcast_020609.pdf.

health coverage, he was charged only his Kaiser co-insurance and averted not just a severe threat to his health but also a $27,000 financial catastrophe. His positive experience with the health care system is one he now recounts to his co-workers, friends, and family thereby encouraging them to access health care when they need it as well. Not only does this benefit the individuals involved, but it also spares taxpayers the great expense of uninsured emergency room care.[10]

Access to health care for restaurant employees has public health implications as well. More than half of all foodborne illness outbreaks reported in the United States are associated with restaurants.[11] Just one sick restaurant worker can infect scores of customers. For instance, the Centers for Disease Control and Prevention reported that in 2006, restaurant

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[10] The typical cost of an appendectomy at San Francisco General Hospital totals more than $19,000. Emergency room visits by uninsured patients at San Francisco General Hospital declined by 70% from 2007 to 2008 (29,976 in the second quarter of 2007 and 8,944 in the second quarter of 2008). Data from the first quarter of 2009 show 5,560 visits, a 81% decline in emergency room visits since 2007. Healthcare Information Division, Office of Statewide Health Planning and Development (OSHPD), State of California, *Hospital Quarterly Financial and Utilization Data Files* (2007-2009), *available at* http://www.oshpd.state.ca.us/hid/Products/Hospitals/QuatrlyFinanData/CmpleteData/default.asp.

[11] Timothy F. Jones & Frederick J. Angulo, *Eating in Restaurants: A Risk Factor for Foodborne Disease?*, 43 Clinical Infectious Diseases 1324 (2006).

workers in a Michigan restaurant likely infected over three hundred and fifty patrons with the norovirus.[12]

A review of foodborne disease outbreaks resulting from contamination by food-service employees found that 89% of the outbreaks occurred at food service establishments and 93% of them involved employees who were ill either prior to or at the time of the outbreak.[13] In San Francisco and Los Angeles counties, between 11 and 12% of disease outbreaks involve an ill food service worker.[14] In the absence of an employer contribution requirement, restaurant workers with no health benefits may delay seeking medical care or avoid care altogether.[15]

The Health Care Ordinance plays a crucial role in protecting the health of workers and the public without imposing unreasonable financial burdens on individuals, taxpayers or employers.

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[12] Centers for Disease Control and Prevention, MMWR No. 56, *Norovirus Outbreak Associated with Ill Food-Service Workers Michigan, January-February 2006*, 1212 (2007).

[13] Jack Guzewich & Marianne P. Ross, Food and Drug Admin., *Evaluation of Risks Related to Microbiological Contamination of Ready to-eat Food by Food Preparation Workers and the Effectiveness of Interventions to Minimize Those Risks* (1999).

[14] *Public Health Impacts on the Healthy Families Act: Hearing on H.R. 2460 Before the Comm. on Educ. and Labor*, 110th Cong. 6 (2009) (statement of Rajiv Bhatia, Director, Occupational and Environmental Health, San Francisco Department of Public Health).

[15] *See generally* Jones & Angulo, *supra* note 11.

III. THE ORDINANCE LEVELS THE PLAYING FIELD FOR COVERED BUSINESSES WITH MINIMAL ECONOMIC IMPACT ON THEM.

Employer contribution requirements are widely accepted policy solutions to the problem of the working uninsured, and indeed have featured prominently not only in local and state health reform efforts but also in national health reform proposals dating back to the Nixon administration in the 1970s and, more recently, to the 1990 report of the Pepper Commission (the Bipartisan Commission on Comprehensive Health Care). Maintaining workplace insurance among employers willing to continue providing it, while creating a relatively low-cost alternative for employers that do not, is an idea with bipartisan support that has appeared in health care reform proposals from leading business groups.[16] Current health reform efforts include Congressional proposals with employer contribution requirements.

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[16] Ken Jacobs & Jacob S. Hacker, Berkeley Ctr. on Health, Econ. & Family Sec., *How to Structure a "Play-or-Pay" Requirement on Employers: Lessons from California for National Health Reform* (2009).

A. Employer Mandates Protect Employers Like Zazie from Cost Shifting and Adverse Selection.

Maintaining the structure of the employer mandate in the Health Care Ordinance makes good policy sense. Employer contribution requirements level the playing field in several ways.

First, when some employers fail to provide health care coverage to their employees, or provide it only to an upper-echelon minority, it is well-documented that this shifts costs onto employers that do provide coverage.[17] When uninsured individuals use health care services and cannot pay for them, health care providers make up for the uncompensated care by charging health insurers more for insured patients than what it actually costs to care for them. Insurance companies in turn shift those cost increases onto employers in the form of higher premiums.[18] The cost shift is significant, amounting to a national average of $1,100 per family premium and $410 per

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[17] Ben Furnas & Peter Harbage, Ctr. for Am. Progress Action Fund, *The Cost Shift from the Uninsured* (2009); Families USA, Pub. No. 05-101, *Paying a Premium: The Added Cost of Care for the Uninsured* (2005); Inst. for Health Policy Solutions, *Covering California's Uninsured: Three Practical Options*, Cal. HealthCare Found. (2006); Peter Harbage & Len M. Nichols, *A Premium Price: The Hidden Costs All Californians Pay in Our Fragmented Health Care System*, *in* Issue Brief: New Am. Found. 2006 (New Am. Found. Health Policy Program No. 3, 2006).

[18] Furnas & Harbage, *supra* note 17.

individual premium; by 2013, it is expected to increase to $1,300 and $480, respectively.[19] In California, the cost shift or excess payment by employers that provide coverage to compensate for those that do not is already $1,400 per family premium and $500 per individual premium.[20]

Second, employers that provide no coverage to their employees shift costs onto employers that provide spousal and dependent coverage.[21] Employers resent the financial burden this cost-shifting creates. Employers surveyed in twelve nationally representative metropolitan communities "complained that they . . . were 'subsidizing' other employers."[22] The Health Care Ordinance alleviates the burden on employers that wish to cover their employees.

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[19] *Id.*

[20] *Id.*

[21] *See* Eric E. Seiber & Curtis S. Florence, U.S. Small Bus. Admin., *Changes in Family Health Insurance Coverage for Small and Large Firm Workers and Dependents: Evidence from 1995 to 2005* (2009) (finding that in 2005, 47% of small-firm workers with a large-firm spouse, and 23.5% with a small-firm spouse, were covered as dependents); *see also* Henry J. Kaiser Family Foundation, *Fact Sheet: Women's Health Insurance Coverage* (2008) (finding that "[a]lthough job-based coverage rates are similar for women and men, women are less likely to be insured through their own job (39% vs. 49%, respectively) and more likely to have dependent coverage (25% vs. 13%)").

[22] Lydia E. Regopoulos & Sally Trude, *Employers Shift Rising Health Care Costs to Workers: No Long-term Solution in Sight*, *in* Issue Brief: Findings from HSC 2004 (Ctr. For Health Sys. Change No. 83, 2004).

Finally, without an employer expenditure requirement, employers that do provide health care coverage face increased costs through the effects of adverse selection, as sicker employees who cost more tend to seek out jobs with better benefits.[23]

By spreading the cost of employee health care among all medium and large employers rather than burdening just a few good actors with the cost of care, the Health Care Ordinance creates a level playing field for business.

B. The Health Care Ordinance Allows Zazie To Provide Health Coverage to Its Employees Without Facing a Competitive Disadvantage.

Employers that do not provide health care benefits have lower hourly employee wage costs than those that provide such benefits, and absent a level playing field can therefore compete with lower prices. Before the ordinance went into effect, Zazie wanted to provide health coverage to all its employees but could not because doing so would have put the restaurant at a competitive disadvantage. Zazie estimates that the cost of health care would amount to 50% of its profits were it not for the level playing field created by the ordinance. Zazie now fully funds the cost of health care through a $1 surcharge for every

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[23] Lawrence H. Summers, *Some Simple Economics of Mandated Benefits*, 79 Am. Econ. Rev. 177 (1989).

customer, a practice that 25% of all San Francisco restaurants have now adopted in some form.[24] It is safe to assume that most other restaurants also pass on the cost to their customers through more traditional means, such as raising prices.

In addition, the majority of employers that fail to cover all or most of their employees – including most GGRA members before the ordinance went into effect[25] – operate in industries in which their competitors do not offer coverage to all employees either.[26]

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[24] The typical surcharge is 4% of the bill though some restaurants like Zazie use a specific dollar amount instead. Carrie Colla, William H. Dow & Arindrajit Dube, UC Berkeley School of Public Health, *How Do Employers React to a Pay-or-Play Mandate? Early Evidence from San Francisco*, Mimeo (2009). Other industries would be expected to pass on health care costs in the form of price increases, as happens in response to minimum wage requirements. *See* Daniel Aaronson, *Price Pass-Through and the Minimum Wage*, 83 Rev. Econ. & Stat. 158 (2001).

[25] The most recent data available from a GGRA survey show that in 2005, 86% of restaurants answering the survey offered health insurance to at least some of their employees. Of these, almost 60% offered health insurance to their full-time employees (those working thirty-six hours or more per week), 25-30% offered health insurance to their part-time employees working twenty to thirty-five hours per week, and 2% offered health insurance to their part-time employees working fewer than twenty hours per week. Kent Sims, Golden Gate Rest. Ass'n, *Economics of the San Francisco Restaurant Industry* (2005), *available at* http://www.ggra.org/PDFS/Ec%20Study%2005.pdf.

[26] *See* Arindrajit Dube & Michael Reich, Univ. of Cal. Inst. for Labor and Employment, *2003 California Establishment Survey: Preliminary Results on Employer Based Healthcare Reform*

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Zazie wanted to provide health insurance to all its employees before the Health Care Ordinance passed, but had no rational way to do so. Raising food prices would put the restaurant at a competitive disadvantage, and the $1 surcharge that Zazie has now adopted functions only because other restaurants in the city pass on health care costs to customers as well.

The Health Care Ordinance ensures fair, across-the-board requirements for employers. Indeed, research demonstrates conclusively that restaurants in San Francisco experience no ill effects from the Health Care Ordinance.[27] The ordinance creates an opportunity for employers that wish to cover their employees: it allows Zazie to pass on the cost of health care to customers without impact on its ability to compete.

(2003) (finding that retail, restaurants, hotels, construction, and business services comprise the industry sectors with the greatest share of the uninsured).

[27] A comparison of San Francisco businesses to those in surrounding areas found no indication that overall employment, or employment in the restaurant industry, grew any slower in San Francisco than in comparable surrounding areas after the Health Care Ordinance passed. Colla, Dow & Dube, *supra* note 24.

C. Despite Petitioner's Representations to the Contrary, Most Medium-Sized Business Owners Support Employer Contribution Proposals Like the Health Care Ordinance that Have Minimal Economic Impact on Employers.

In a level-playing-field context, Zazie can provide health care to its employees with no economic impact. Zazie covers the cost of employee health care entirely through a simple $1 surcharge. Indeed, the $1 surcharge funds not only Zazie's Kaiser plan but also dental coverage. Fewer than 1% of Zazie's customers have complained or even inquired about the surcharge and most who do ask out of curiosity. Zazie reports full customer support for the surcharge and the Health Care Ordinance.

Notably, a report by Small Business Majority California found widespread support for an employer contribution requirement from California business owners employing fewer than 100 employees: among respondents, fully 80% of business owners (including 76% that did not currently offer insurance and 84% that did) felt that "employers should pay something to provide healthcare to their employees."[28] Other

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[28] Small Bus. for Affordable Healthcare, Small Bus. Majority, *California Small Bus. Healthcare Survey* (2007).

employer surveys yield similar findings.[29] GGRA does not fairly represent employer sentiment.[30]

D. Employer Mandates Play an Essential Role in Preventing Crowd Out.

Public policy considerations support employer mandates to reduce "crowd out," or the temptation for employers to drop the private insurance coverage they do offer when other options become available to their employees. Were the employer contribution requirement to be struck down and the Healthy San Francisco program to remain, as Petitioner advocates, San Francisco would be left with a publicly-funded program in which uninsured San Francisco residents could enroll at great cost to taxpayers. This would create powerful incentives for employers that currently offer coverage to their employees to drop the

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[29] *See* San Mateo County Blue Ribbon Task Force on Adult Health Care Coverage Expansion, *Opinion Research Regarding Health Coverage Expansion* (2007), *available at* http://www.co.sanmateo.ca.us (56% of business respondents in San Francisco's neighboring county support a plan in which all employers must meet minimum health spending standards by offering health insurance or paying into a county fund, and 72% support a plan like San Francisco's that exempts employers with fewer than twenty employees). *See also* Dube & Reich, *supra* note 26 (64% of business respondents support proposals that require employers to either provide health insurance or pay a fee into a state fund to cover the uninsured and 59% that currently do not offer health insurance also support such a proposal).

[30] Nor does GGRA fairly represent the sentiment of its members as *amicus* Medjool demonstrates.

coverage in favor of the Healthy San Francisco option – now entirely free to them. Crowd out "is much more likely when employers are *not* required to contribute a meaningful amount to the cost of covering their uninsured workers, because the cost of allowing their workers to be covered through subsidized options is so much lower."[31]

Other employer contribution options, such as an across the board payroll tax with subsidies for the Healthy San Francisco program, would frustrate the employer flexibility goal of the Health Care Ordinance and effectively force employers like Zazie to drop private insurance in favor of the publicly subsidized option. Besides encouraging crowd out, a payroll tax would also create labor market distortions and penalize employers that offer higher wages.

In sum, employer contribution requirements benefit business and the economy. Expanding access to health care raises productivity by improving workers' health, increasing their participation in the labor force, decreasing absenteeism and disability, reducing insurance-related "job-lock," and allowing an overall better match between employer needs and employee skills.[32] By expanding access to health care, employer contribution requirements reduce the likelihood that employees will forego necessary medical

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[31] Jacobs & Hacker, *supra* note 16.

[32] *Id.*

care or treatment for chronic conditions.[33] They protect employers from cost-shifting and adverse selection, allow employers to cover their employees without unfair competition, and prevent crowd out. They also enjoy broad business-community support. The Health Care Ordinance is good public policy.

CONCLUSION

The Court should not take up the issues presented in this case. At every level of the proceedings, Petitioner has failed to support the assertions it now makes. Instead, Petitioner and its allies present dire and improbable predictions based on mere speculation. The Health Care Ordinance is a straightforward employer expenditure requirement grounded in sound policy with real benefits to employers, employees, and the public.

[33] *Id.*

The Court should deny the petition for a writ of certiorari.

Respectfully submitted,

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Counsel for Amici Curiae
Zazie and Medjool

August 24, 2009

HEALTHCARE SECURITY ORDINANCE EMPLOYER REGISTRATION AND ANNUAL REPORTING FOR 2008

RETURN TO: SAN FRANCISCO OFFICE OF LABOR STANDARDS ENFORCEMENT
P.O. BOX 7378
San Francisco, CA 94120-7378

FOR ASSISTANCE: Refer to the enclosed instructions, visit http://www.sfgov.org/olse/hcso, or call (415) 554-7892

Business Certificate Number

Business Name and Address

DELINQUENT AFTER 1/31/2009

Covered Employers must complete all of the questions below. Failure to do so shall constitute a violation of § 14.3(b) of Chapter 14 of the SF Admin. Code. Violators shall be subject to penalties and other corrective action.

IF THIS CFC # HOOP RIGHT YOU ARE FILING THIS FORM ON BEHALF OF MORE ENTITIES W/ THE SAME OWNERSHIP

	For each quarter, enter the following information:	1st Quarter January to March 2008	2nd Quarter: April to June 2008	3rd Quarter July to September 2008	4th Quarter: October to December 2008
A	**Number of Employees Employed per Week (anywhere):** *NOTE: Employers with 19 or fewer employees are NOT covered by the HCSO and should NOT complete or file this form*	○ 20-49 ○ 100-499 ○ 50-99 ○ 500+	○ 20-49 ○ 100-499 ○ 50-99 ○ 500+	○ 20-49 ○ 100-499 ○ 50-99 ○ 500+	○ 20-49 ○ 100-499 ○ 50-99 ○ 500+
	IMPORTANT: Time and Expenditure Data for Employees Covered by the HCSO				
B1	**Total Number of "Covered Employees":** *Do not count employees exempt from coverage under this law, see instructions for more details.*				
B2	**Total Number of Employees Exempt From Coverage Under the HCSO,** *including those who have signed Voluntary Waivers*				
C	**Total Number of Hours Paid to All Covered Employees**: *Hours paid includes both hours worked and hours for which covered employees were entitled to be paid wages, such as paid vacation hours, paid time off, and paid sick leave hours, but not exceeding 172 hours/month or 516 hours/quarter.*	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
D	**Total Amount of Health Care Expenditures Made for All Covered Employees** (in whole dollars; do not include commas or cents)	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
E	**Breakdown of Health Care Expenditures Made by the Employer:** *Count each covered employee only once per quarter; if your business made more than one type of health care expenditure for an employee, count that employee in the category in which the largest health care expenditure was made.*				
E1	**Number of Covered Employees enrolled in group health insurance coverage**				
E2	**Number of Covered Employees enrolled in self-insured group health plan.** *Please review the instructions to determine if your plan meets the definition of a self-insured plan.*				
E3	**Number of Covered Employees enrolled in health/medical reimbursement, spending, or savings account administered by a third party vendor**				
E3(a)	*Total annual dollar amount of funds made available to Covered Employees for 2008 – how much the employer made available via third-party health/medical reimbursement, spending, or savings accounts (in whole dollars; do not include commas or cents)*	$			
E3(b)	*Total annual dollar amount of reimbursements made to Covered Employees for 2008 – how much employees were reimbursed via third-party health/medical reimbursement, spending, or savings accounts (in whole dollars; do not include commas or cents)*	$			
E4	**Number of Covered Employees for whom the employer provided direct reimbursement or made direct payments for health care expenses**				
E4(a)	*Total annual dollar amount of funds made available to Covered Employees for 2008 – how much the employer made available for direct reimbursements or payments*	$			
E4(b)	*Total annual dollar amount of funds spent for Covered Employees for 2008 – how much Covered Employees were reimbursed and/or how much was paid directly by the employer for Covered Employees' health care expenses (in whole dollars; do not include commas or cents)*	$			
E5	**Number of Covered Employees for whom payment was made for the City Option** *(includes both Healthy San Francisco and the City's Medical Reimbursement Account)*				
E6	Other: *(describe)*				

By submitting this report the above-named employer certifies the following: (1) that the information on this reporting form is correct; (2) that all compensable hours paid to the employees who performed work in the geographic boundaries of the City and County of San Francisco during the period covered by this report are reported herein; (3) that this report, whether or not signed in the space provided below, is being submitted by the employer or duly authorized representative of the employer. Under the laws of the State of California, I declare under penalty of perjury that I have read the foregoing and that it is true, correct, and complete to the best of my knowledge and belief.

3664

SIGN HERE _____ DATE _____, 2009

PRINT NAME_____ TELEPHONE_____

App. 1